DOCUMENT RESUME

ED 456 596 EC 308 581

AUTHOR	Jordon, Dixie
TITLE	A Guidebook for Parents of Children with Emotional or Behavioral Disorders. Third Edition.
INSTITUTION	PACER Center, Inc., Minneapolis, MN.
PUB DATE	2001-00-00
NOTE	131p.
AVAILABLE FROM	PACER Center, 4826 Chicago Ave. South, Minneapolis, MN 55417-1098. Tel: 800-537-2237 (Toll Free); Tel: 952-838-9000; Fax: 952-838-0199; e-mail: pacer@pacer.org; Web site: http://www.pacer.org.
PUB TYPE	Books (010) -- Guides - Non-Classroom (055)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Adolescents; *Behavior Disorders; Child Advocacy; Children; Clinical Diagnosis; *Emotional Disturbances; Federal Legislation; Individualized Education Programs; Mental Disorders; *Mental Health Programs; Parent Associations; *Psychological Services; School Responsibility; *Special Education; Student Evaluation; Student Rights; *Symptoms (Individual Disorders)

ABSTRACT

This handbook discusses different types of disorders, mental health services, and school services. The first section highlights the importance of parental advocacy and family support networks. This is followed by a discussion of the plight of parents who have a child with an emotional or behavioral disorder and the perspective of a child with emotional problems. Different types of emotional and behavioral disorders are then described. Sections of the book address: (1) considerations parents should evaluate before deciding whether a child's behavior is normal or not; (2) types of professionals that provide mental health services; (3) selecting a mental health provider; (4) some of the different philosophies and therapies; (5) kinds of services parents should consider; (6) services schools should provide (describes special education and related services, evaluation, the Individualized Education Program, academic accommodations, suspensions and expulsions, and federal law); (7) financial considerations; and (8) finding parental support and engaging in child advocacy. A list of relevant organizations is provided, along with a list of parent training and information centers, state Medicaid offices, and the core values and principles for the CASSP system of care. (CR)

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for Parents of
Children
with
Emotional or
Behavioral
Disorders

Third Edition
PACER Center, Inc.

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A Guidebook
for Parents of Children with Emotional or Behavioral Disorders

Written by Dixie Jordan
Paula F. Goldberg, PACER Executive Director

PACER CENTER

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Special thanks to Gordon Wrobel, Dianna Herrmann, and James Mason for reviewing previous editions of this book.

Views expressed in this guidebook do not necessarily reflect those of any funding source.

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Organizations Concerned with Children's Mental Health

Organizations for Parents of Children with Emotional or Behavioral Disorders

Parent Training and Information Centers

State Medicaid Offices

Values and Principles for the CASSP System of Care

Introduction

Background

In 1982, a remarkable book, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services,* by Jane Knitzer (Washington, D.C.: Children's Defense Fund), reported that two-thirds of all children with serious emotional disturbances in the United States were not receiving the services they needed. Many others received inadequate, inappropriate or unnecessarily restrictive care, sometimes in state hospitals. Although many of these children required services from more than one agency, few states had any organized planning process for coordinating such services.

To address the needs clarified in *Unclaimed Children,* Congress funded a small program in 1984 to help states to develop mental health systems that would work for the unique needs of children. That initiative, known as the Child and Adolescent Services System Program or CASSP, began a first-time look at considering the needs of children within the context of their families.

In *A System of Care for Severely Emotionally Disturbed Children and Youth* (1986), Beth Stroul and Robert Friedman described a framework to develop community-based systems of care for children and their families, to ensure that services were coordinated, comprehensive, and child focused, and that they included parents as primary partners.

Over the last fifteen years, state and federal agencies have stepped up efforts to build such systems of care in communities across the nation. Simultaneously, families of children with emotional disorders have mobilized to petition states and communities to provide services for their children that included them as active partners.

Today, the active participation of parents in developing and implementing services for their children and families has become the national standard for how all children's services should be provided. This approach is a radical departure from past models, because it includes families from a strengths-based perspective and recognizes them as essential contributors to their children's well-being.

We have learned that services that build on the strengths and abilities of families not only help the child, but also strengthen the ability of families to successfully keep their children at home and within their own communities. The increased participation of parents in policymaking continues to be critical to sustaining the movement to services that respect the strengths and unique abilities of families of children with mental health needs.

Parent Training and Information Centers

Nearly one hundred Parent Training and Information Centers (PTIs) and Community Parent Resource Centers (CPRCs), located in every state, provide information and guidance to parents of children with all disabilities, including those with emotional and behavioral issues. The responsibility of a federally funded PTI is to help parents to understand their child's disability and their unique role in special education planning. PTIs also help families locate resources and provide information on effective collaboration with schools and agencies serving their children, including processes for resolving disagreements when they arise.

PACER Center, the publisher of this book, is the Parent Training and Information Center (PTI) that serves Minnesota parents. PACER is the national coordinating office of The Technical Assistance Alliance for Parent Centers (The Alliance) that provides technical assistance to parent centers and community parent resource centers nationwide. To contact the PTI and CPRC that serves you, see pages 109-117.

Family Advocacy and Support Networks

In 1988, a national gathering of parents and advocates decided to form a new organization with an exclusive focus on addressing the mental health needs of children with emotional disorders through a strengths-based approach. Out of this decision, the Federation of Families for Children's Mental Health (FFCMH) was created. This family-led national organization now has chapters in all states and in many communities, and works to develop policies that affect children's rights to appropriate mental health and other support services. The FFCMH believes that it is in the best interest of the nation to provide quality services to all children with mental health needs regardless of how those problems originate, and to ensure that their families receive the support and information they need to help their children.

Organizations that effectively serve families of children with mental health concerns now exist in many states. In addition, less formal networks of families and self-help groups in local communities provide support and information to families who are dealing with extraordinarily difficult day-to-day problems or struggling with feelings of shame or blame for their child's problems. Families have begun to recognize their own political presence and often participate with providers and other professionals to develop policies that affect service design and delivery at national, state and local levels. Many states currently require the participation of families in service development, and the number is growing. In many communities, families have organized and are working with providers to develop services, (self-help groups, respite care, information resources) that have not previously existed for children who have mental health needs.

For current information on family initiatives to assist parents of children with emotional disabilities, contact PACER Center's EBD Project at (952) 838-9000, or the Federation of Families for Children's Mental Health, at (703) 684-7710.

Family Choices

Though there are still many gaps in the services available to children and adolescents who have emotional or behavioral concerns or mental illnesses, there are also many fine programs and services in place and numerous accomplished and caring providers who work with children and their families. This book is for families who want to understand more about the different programs that may be available to serve children and youth, and about their own strengths and abilities in supporting their child's healthy development. Our goal is to provide information and referrals to local resources that can assist you in making informed decisions about services for your children.

In general, mental health and other support services for children with emotional or behavioral disorders focus on the importance of receiving services in regular settings, such as the child's home, school, and community rather than agency, group home, or institutional placements, whenever possible.

New community-based services are based on the understanding that families are vital to the well-being and continuing health of their children. Respect for family choices, family strengths, and family priorities is integral to success. We believe that families must be provided with information about their rights and their responsibilities in the systems in which they or their children receive services. They must also receive information on how to work effectively with providers and within systems. In other words, the information you know about your child, including health, relationships, school performance, likes, dislikes, fears and accomplishments, will be used to develop a services plan that meets the needs of your child and your family.

Recognizing and respecting the strengths of families is key to the success of community-based children's mental health and family support services.

Who Do We Blame? What Good Does It Do?

by Barry Haddle

It seems to be an ingrained part of human nature to look for someone to blame whenever anything goes wrong. This is especially true whenever something goes wrong with a child. Parents blame teachers, teachers blame parents, and they both blame administrators. Even if it were possible to establish blame, what good would it do the child?

The people who suffer most from this blame seeking are the parents of children with emotional and behavior disorders.

Whenever a child has an obvious physical handicap, very few people are insensitive enough to suggest that the parents are at fault. No one says to the parents of a blind child, "If you had raised him properly, he would not be blind." Most people would have more respect for the feelings of the parents of a severely retarded child than to blame the parents for their child's affliction.

We have compassion for these parents and their children. We try to help if we can. The parents of children with mental and emotional handicaps, however, are fair game for all. They must listen to remarks such as: "If he were my child, I'd make him listen!" "The only thing that girl needs is a good spanking!" "He's just lazy, you've got to make him learn!" "What kind of parents would raise a kid like that?" and so on. I'm certain that many more examples could be given by parents who have been victims of such cutting remarks.

Consider the plight of these parents. They often blame themselves. Consumed with guilt, they ask themselves, "What have I done wrong?" In desperation, they seek help from "professionals." They go from agency to agency, all professing to help troubled children. They read book after book written by "experts." They receive counseling and attend seminars. Many spend their savings in a fruitless effort to "find a cure." A few lucky ones do get help, but the success rate is dismally low. For the unlucky majority, the feeling of hopelessness increases as they see little improvement despite all their efforts. Many see a future full of heartache and little hope.

These parents do not need the additional punishment brought on by callous remarks made by others.

The blame-seekers never explain how parents of troubled children can also have "good" children in the same family, nor how some lazy, lawless and otherwise unfit parents can have "good" children. If the parents were always to blame, this would never happen.

Rather than looking for someone to blame, we should all work together to see that the necessary resources are allocated to conduct research and find solutions to these problems. I do not mean that we need more people to invent half-baked theories so that they can write books and conduct lectures. These do nothing more than enrich authors by preying on the desperation of parents willing to try anything.

We need legitimate research by scientists. We need answers about how the mind really works and how it is influenced by body chemistry. Such research, of course, is being done, but not on a scale that bears any relationship to the magnitude of the problem. We need a research program to improve the quality of human life that has the scope of the Manhattan Project.

The whole country would benefit and many presently unhappy parents and children would be eternally grateful.

From *Exceptional Parent* (December 1982). Reprinted with the express consent and approval of *Exceptional Parent,* a monthly magazine for parents and families of children with disabilities and special health care needs. Subscription cost is $36 per year for 12 issues; call 877-372-7368. Offices at 555 Kinderkamack Rd., Oradell, NJ 07649.

Jeff's Story

Jeff wrote the first section of this story for *A Guidebook for Parents of Children with Emotional or Behavioral Disorders*. The subsequent updates span twelve years.

Jeff, age six

For most of us, the intensity of a painful experience seems to fade gradually with the passage of time. It is part of a healing process that allows us to continue with our lives. But for Jeff, the intensity of his pain has remained with him . . . a kind of "hidden heartache" that interferes with his ability to cope and react to life in a normal way. Just to look at Jeff, he appears to be like any other six-year-old. He likes Star Wars, Pac Man, riding his Big Wheel, and playing baseball . . . and sometimes he likes to play with other children.

The difference is that although Jeff may look like other children, he is not. Jeff, who came to us from Korea at six months, was suffering from a serious emotional disorder. When the flight aide placed Jeff in my arms, there was an unmistakable difference in the way he reacted. He didn't cry or move but maintained a rigid position and continued a cold, blank stare. I was reassured that sometimes children react this way from a long flight. However, the staring continued, compounded with head banging, poor appetite, and stomach problems.

As time progressed, Jeff spent much of his time rocking, banging his head, and exhibiting destructive, overly active and inappropriate behavior. When he was eighteen months, I felt I would no longer accept the many excuses for his behavior from family members, doctors, and other professionals. I was determined that my son would receive the help he so desperately needed.

I thought, "After all, I am Jeff's mother. I live with this child all the time, and I know he is not improving. In fact, he is distancing himself further from us."

And so my search began for help for Jeff. Unfortunately, I did not realize at the time that the number of programs, available treatment, or even recognition of emotional disorders in young children was very limited. At the beginning, the treatment centered around sessions with a child psychologist who took an in-depth history of Jeff, his behaviors at home and those observed during our visits with the doctor. There was a great deal of discussion concerning parenting skills, and the doctor provided suggestions for working with Jeff at home.

Most distressing during this first phase of treatment was the endless number of questions asked of me in the sessions. It seemed as if they were probing for some "deep, dark secret" in our family that would reveal why Jeff was responding the way he did to the world around him. But there *was* no hidden resentment toward Jeff. He had come to us with his problems intact at six months. It has taken me a long time to recover from the misplaced guilt that was imposed on me in the beginning.

After six months of treatment, it was determined that more intensive observation of Jeff was needed in a hospital setting. I felt so miserable and guilty at the thought of Jeff going into the hospital. However, I was exhausted trying to cope with his behaviors all day long. He had to be watched constantly. There was really no other choice. Even routine activities most people take for granted, such as grocery shopping, visiting friends, and attending church, were all but impossible when Jeff was along.

Also, it was very difficult to find anyone who was willing to watch him so that I could get out myself. Many times I had to drive fifteen miles to my parents' home to have Jeff watched, or they would have to drive to my house, so I could get some of those errands accomplished.

I envied parents who didn't have all these problems and felt angry that no one other than my family offered help. Friends and acquaintances would invite my daughter to come to their home, but no one wanted to deal with the "strange little boy."

Jeff was hospitalized for one month, during which we were carefully scrutinized concerning our parenting, our own childhood experience, and our families. For much of the hospital stay, we were not allowed to visit with Jeff unless a staff member was in attendance. Some of the staff were kind and helpful. Others were uncaring and judgmental.

I longed to tell them how I would love to come and judge and comment upon every interaction they had with their own children. I highly doubt they would pass the stringent criteria they had set for us.

During that month I tried to focus my thoughts on one goal: that the doctor could diagnose Jeff's problems and begin some course of treatment. At the end of the month, the doctor had indeed observed many of the behaviors that I had described to her so many times during our sessions at her office. She recommended Jeff for a new hospital-based program that worked with children who were emotionally disturbed.

Jeff made progress during the next two years in this program. He was in a small, safe environment with teachers and therapists to work with him. There was also a therapist who helped parents understand their child's behaviors. Learning effective and new ways to parent Jeff and gaining a greater understanding of his delayed development were most helpful.

Again, during this time I was put through intensive analysis. One week the therapist or teachers would praise and encourage me in how I was working with Jeff . . . by the next week I was either blamed or criticized for some of the same actions. It was difficult for me to cope with the inconsistency of their methods. The inconsistency also created needless damage to my own self-esteem.

After leaving the hospital program, Jeff was referred for treatment with a child psychologist who had established an excellent relationship with him. We saw another doctor in the same group for counseling. The attitudes that these doctors had toward parents were very different from what I had experienced before. They were very open, honest, and consistent in their dealings with us. Their major focus was not to put needless stress on a family already pushed to an almost unbearable level of stress. Rather, they focused on ways to help us cope with, understand, and accept Jeff's disorder. As a family, we can act in ways that will stimulate growth in Jeff and help him feel a sense of safety. Nevertheless, to be realistic is to accept that he may never be able to function like other children.

Jeff is now in public school, receiving services from special education through an emotional and behavioral disorders program. Within the public school system, I have found there are those who care deeply about doing what is appropriate for Jeff. There are teachers who care deeply about doing what is right for him. There are teachers and administrators who have taken the time to look carefully at his long history of emotional problems, listened to my observations of Jeff and his feelings about school, and implemented suggestions from his doctor. These people feel it is important to work as a team.

Unfortunately, there has been an equal number of school personnel who cannot see past Jeff's normal physical appearance. They make snap judgments and recommendations that I feel are detrimental to his well-being. These teachers will not accept that a bright child who looks so normal—and at times, who can function normally—can have serious emotional problems. Their opinion is that he is manipulative and spoiled. How I wish he were! I could do something about that.

Jeff is consumed with fears that he may be killed. He believes that teachers and other children can change into monsters. He has a distorted perception of what is actually happening, and I worry that he will injure another child or himself while at school.

Being the parent of a child with an emotional disorder has certainly not been easy. At times, I am so tired and sad and helpless. Now, six years later, I wonder where I found the strength to make it through those early years. Many times I felt as if I was struggling all alone, and I wondered if there was any hope for Jeff.

To parents who wonder how they are going to survive living with a child with an emotional disorder, I want to say that there are people who do care about you and your child. Sometimes, you have to be the one to seek out these people.

PACER Center was there for me when I was questioning whether anyone really cared what happened to Jeff. At that time, I was unaware that my child was entitled to a free, appropriate public education under Public Law 94-142 (now known as the Individuals with Disabilities Education Act, or IDEA). I received information from PACER staff, attended workshops on the basic rights and laws, and received advocacy and assertiveness training. Since most of PACER's staff are themselves parents of children with disabilities, they have a deep concern and empathy for all parents. I learned that parents can be an important part in developing an appropriate program for their child, and I gained the skills and confidence to become a good advocate for my son.

In the future I would like to see the establishment of support groups for parents of children with EBD. Parents need to feel less alone. Professionals need to consider parents as individuals. We do not all fit into one mold. It does not help to blame parents for their child's problem. What *does* help is to enable them to understand, cope with, and accept the child, and to teach them ways to help their child.

Professionals work with our children on a limited basis. The youngsters do present frustrations. However, professionals are able to have a break from this frustration. Parents have to cope with the situation daily.

Parents need to show appreciation to those professionals who put forth an extra effort with their child. Professionals need to feel that we recognize and value these efforts. Parents and professionals should to work as a team.

In the past six years, my life has changed dramatically. My values and priorities are different. I've become a much stronger person. Having Jeff has put an enormous amount of stress on our family. Not all family members are able to accept or cope with a child who has an emotional disorder. Some may never be able to overcome their feelings of anger, frustration, and resentment. That is a part of reality that I have come to accept.

Jeff's future is uncertain right now. He makes progress and also experiences regression. During these years, I have had to give a lot of myself; it has been worth it. But I have also learned it is important to do something for myself, too.

Jeff, age fourteen

Jeff is now almost fourteen years old and in the eighth grade. The little boy who was once so dependent on us has grown into an adolescent preparing to face the world in his own way. His "own way" is different from that of other adolescents. He can be aggressive and hostile, and yet there is a very vulnerable side to Jeff, too. The issues that faced our family with a child with an emotional disorder have been replaced by new and different concerns with an adolescent. The little boy who lashed out in anger is now taller and stronger than I am, and new techniques must be used to manage behavior.

We have all rejoiced in the successes he has experienced along the way—swimming on a varsity team at our local high school and an award for academics and attitude for one quarter during his first year in junior high. These are the memories we cling to when we are forced to face the fact that our son's emotional disorder is not going to go away.

Jeff still views life differently from others. He has difficulty controlling his impulses, steals from stores and other people, and has low self-esteem. Medication, which was ineffective at a younger age, is now helping him cope with his daily routine. Individual therapy has been replaced with group therapy for adolescent boys. This has been a safe and reassuring place for him to go, a place where he feels accepted and understood by others. Jeff is also becoming an important member at the individualized education program (IEP) meeting. He is learning to advocate for his own needs and to feel that he is able to determine goals for his own life.

Finding support and reaching out to other parents whose children and adolescents have emotional disorders have been a very important part of my life. Like Jeff, I needed the kind of support and sharing that comes from being with others who understand the difficulties in managing an adolescent with emotional disorders. Attending a support group offers me the chance to talk freely with people who are caring and nonjudgmental.

Throughout the past fourteen years, professionals have frequently entered and exited our lives. Some were sure they had the answers. What I have found is that Jeff's abilities fall somewhere in the middle of all those varying opinions. What the future holds for Jeff remains uncertain. However, I recognize the need for good transition planning and support for independent living skills. Jeff deserves a chance for a life that is fulfilling for him. I recognize that this transition will be handled in his "own way" too.

Jeff, age eighteen

Graduation is a time for reflection about the past and anticipation about what the future will hold. On June 7, Jeff graduated from high school. As a parent, I feel pride in Jeff's accomplishments, relief in knowing I never have to attend another IEP meeting where too often my son was not understood, and apprehension about what will happen in the future.

Jeff did not feel valued as a person and as a student within his high school, even though he received many awards as a member of the swim team. It was important for him to feel connected—to feel that he belonged. Unfortunately, that did not happen.

I wish I could say that the past eighteen years have not been difficult, but that would not be true. We have had to face many times when we did not know if Jeff, who often spoke of committing suicide because living was just too hard, would make it through another day. We located help for him, and offered our own support, but often he rejected that help from us. Jeff said he did not need a family.

Jeff has struggled with many issues in his life. We have felt anger and frustration but were determined, as most parents are, to find help. Fortunately, his special education teacher helped us locate a community counseling resource where Jeff felt safe and accepted. Most important, we did not give up.

Throughout the years, we have had to devote a great deal of time and energy to Jeff. We knew it was important to learn as much as we could about his attention defecit hyperactivity disorder (ADHD) and other emotional disorders. In the end, after all the tears, the blame, and the exhausting search for appropriate services, we found the kind of supports our son and our family needed. It has been worth all the work.

Jeff is now in his freshman year at the University of Minnesota. He decided to ask for help with school from the Disability Services Office on campus, and determined, with the staff, what accommodations he needs to succeed in college.

For Jeff, this is a new beginning. It is a story that only he can tell. I have asked him to share his reflections with other parents, and what follows is Jeff's review of his life in his own words. I hope that others will listen carefully, for, through his own unique style and perspective, Jeff brings a message of hope and inspiration to other families.

Jeff: My life in review

I'm writing this story as a favor to my mother and sort of as a favor to myself. I'm also writing this to try to give to all of you who are reading a better understanding of what attention deficit hyperactivity disorder (ADHD) and other emotional problems are like and how I have progressed to where I am today. Since I am writing this off the top of my head, I might jump from idea to idea. In other words, it may be kind of jumbled. I'm sorry if there is any confusion in comprehending my words. Please bear with me.

To begin, I'll tell you a little about myself. I am eighteen years old, a graduate of high school, attending the University of Minnesota, and I have ADHD. That last one, I'm pretty sure you already knew.

As a student, having ADHD has caused difficulties along the way. It was hard for me to stay on task and sit through long lectures. I couldn't really learn through auditory teaching methods (like lectures). I am taking Ritalin to help with problems and find that taking it helps a lot. Also, through the years I have seen doctors, psychologists and other professionals to try and help me with my disability.

I can say truthfully that professionals did help quite a bit in the short run, but there are a few things that parents and other adults may overlook that are also big factors.

One of those things is having good friends. When I say "good friends," I mean friends who actually care. All the way through high school, I didn't have a lot of friends, but I did have a few good friends. Although they did not know about my disability, indirectly they helped me, always being there and nudging me in the right direction. In the couple of months I've been at college, I've already made some close friends. If I didn't have friends looking out for me the way they do, my college life would be a lot rougher than it is now. I consider myself lucky to have such friends.

The other thing that I haven't mentioned but is necessary to mention, is my family. My family has been with me my whole life. Without them, I do not know where I would be right now. Both my mother and my father have helped me through my problems. They've put up with me for eighteen years of their life, and probably will for the rest of their lives, too. My family gave me something that no hospital, doctor, psychologist or medication could give me—their love and caring. My parents fought to keep me out of residential placement and for that I am very fortunate. Without their love and caring, I'd either be a cold person without any motivation in life, or I'd be away from all my family and friends in some hospital or correctional camp setting. I couldn't even imagine that.

At this point, I would like to thank my mother and father very dearly for sticking with me this long. I know it wasn't easy for them. It wasn't easy for me, either. But, together, along with all the other help, I've made it this far. I'm not about to give up.

All through this paper, I've been trying to get one point across. The medical field can only help so much. I've run into people that think medicine and doctors are the "solution" to the disabilities that kids like me have. I hope I have proven that wrong, because it is. They are only part of the solution.

What Is an Emotional or Behavioral Disorder?

Although childhood is generally regarded as a carefree time of life, as many as 14 percent of children and adolescents experience emotional or behavioral difficulties growing up. Some children are born with different abilities to handle stress or other environmental demands. Others may develop emotional problems as a result of how their brain functions. Some live in unsafe neighborhoods that cause them stress, and others are exposed to chemicals, drugs, or other toxins that affect development.

The question of who or what causes emotional disorders, however, is not as important as understanding that the factors affecting how children develop emotionally are almost limitless. When children behave in a way that is not considered "normal" for their particular family group, community, or culture, it is important for families to seek help immediately.

The last decade has produced many advances in helping children with emotional problems. Research has shown that brain function (the way the brain receives and processes information) is different for some children with emotional disorders, and that viewing the problem as having a medical basis can be helpful. Other children respond best to supports for positive behavior or training to help them develop skills. Building friendships or positive relationships helps still others.

Interviews with the child, parents, and other family members are important sources of information to help professionals arrive at a diagnosis. They can also help in developing a plan to allow a child to remain at home while services are put into place. Even children who do not have a neurological or other biological basis for their problems still need services to help them learn appropriate skills and to help the family effectively support the child at home.

Many parents are confused by the array of diagnoses their child may receive from different mental health professionals. Children's behaviors exist on a continuum, and there is no specific line that separates troubling behavior from a serious emotional problem or mental illness. Rather, emotional or behavioral problems can range from mild to severe.

Diagnosing Mental Health and Emotional Disorders

A *mental health diagnosis* is the result of a professional assessment based on one of several classification systems used in the United States. A diagnosis represents a professional's best guess, based on a child's behaviors and information provided by families, that the child has a specific disability that needs attention. A child may be given a diagnosis when his or her behaviors occur frequently and are severe. The most familiar system used for determining if a child has a specific emotional disorder is the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (DSM-IV), written by the American Psychiatric Association.

The DSM-IV describes behaviors that help determine whether a child has an emotional, behavioral, or mental disorder. It provides guidelines to professionals in diagnosing problems. Care must be taken that cultural differences and other factors such as race, socioeconomic status, or the behaviors of the child's parents at the time of evaluation do not have an effect on professional opinion.

The focus on identifying specific behavioral and emotional characteristics is important when deciding what to do about a problem. A DSM-IV diagnosis actually serves several purposes. First, it helps to determine whether a child has a problem that has an accepted treatment standard, such as the use of medication to treat depression. Second, a professional diagnosis may be required for services to be eligible for insurance coverage or Medicaid. Without the diagnosis, insurance companies may refuse to pay for some services a child needs, such as day treatment or a therapeutic art program.

Parents should insist that the issues they are concerned about be discussed during the evaluation. Sometimes family situations, such as the recent loss of a family member or a child's frustration with a learning or social problem, lead to behaviors that may be inappropriately diagnosed. These nonmedical issues must be carefully considered by the evaluator to be sure that the evaluation is accurate. Determining whether a child has a neurobiological disorder, a behavioral problem, or an emotional disorder helps families and providers decide what services will be the most useful to help support a child and family and to help the child learn new skills. An evaluation should result in a set of recommendations for how to help your child.

Whether your child needs services should not depend entirely on whether he or she has a "label" but on whether he or she needs help to change a pattern of behavior that is interfering with success. You should insist on a list of specific written recommendations on how to help your child as a result of any assessment or evaluation process.

For example, the DSM-IV lists eighteen separate characteristics of behaviors that are related to attention deficit hyperactivity disorder (ADHD). If your child has six of the signs that are used to diagnose inattention or six of the signs of hyperactivity or impulsivity, he or she may be given a diagnosis of ADHD. This means that the mental health professional believes your child has a medical problem and may recommend a specific therapy, such as medication or a behavioral or counseling program.

But what if your child has only five of the signs, but still cannot pay attention and is still failing in school? Specific strategies that help a child deal with being distractible, forgetful, or impulsive will be useful, whether or not your child has the diagnosis of ADHD.

It is usually more helpful when parents concentrate not on the cause of a disorder but on their important role in teaching their child new behavior skills. A child who is called "emotionally disturbed" probably does the same things that all children do. The inappropriate behaviors may happen more often, however, or the behaviors may be more extreme. Most people simply cannot handle the kinds of behaviors exhibited by children who have emotional disorders without professional help. Their child's need for structure or support is simply greater than most parents can provide without help.

Philosophies of Mental Health

Different professionals view emotional and behavioral disorders in different ways. How professionals look at the cause of emotional problems and what they recommend is usually shaped by their background, training, and experience, as well as their philosophy about how emotional disorders begin.

Though the philosophy of the provider may not seem important to you when you are frantically seeking a way to help your child, we strongly recommend that you discuss your beliefs with providers you contact. Since a child's treatment program will stem from the provider's philosophy, families should be sure they agree with "where the professional is coming from," as well as with the recommendations made to help their child. If you do not agree with your child's assessment or treatment plan, you may not be comfortable carrying out or participating in the services. Parents should always feel comfortable in seeking a second opinion if they disagree with the services being recommended by the mental health professional.

Emotional and Behavioral Disorders

The following examples of emotional and behavioral disorders are from the DSM-IV diagnostic criteria. This list is not comprehensive, but is included to give examples of emotional disorders affecting children and youth, and information about how those disorders are diagnosed.

Adjustment Disorders

Adjustment disorders describe emotional or behavioral symptoms that children have when they are unable to appropriately adapt to stressful events or changes in their lives. According to the DSM-IV, an adjustment disorder is characterized by "clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors." The symptoms, which must occur within three months of the stressful event or change in a child's life and last no more than six months after the stressful event ends, are (1) marked distress that is greater than what would typically be expected from the event(s), or (2) a significant impairment in social or occupational (school) functioning.

Adjustment disorders are relatively common, ranging from 5 percent to 20 percent of children.

Anxiety Disorders

Anxiety disorders are a large family of disorders, such as specific phobias (fear of school or fear of heights, for instance), social phobia, post-traumatic stress disorder, avoidant disorder, obsessive-compulsive disorder, panic disorder, and panic attacks. The main feature is excessive anxiety.

Anxiety disorders may show up in physical symptoms (such as headaches or stomachaches) or in conduct or behavior (refusing to do school work, etc.). They may also appear in the child's emotional response, such as giggling or crying at inappropriate times. Anxiety is a temporary reaction to stressful experiences at home or in school. When anxiety is intense enough to interfere with how a child gets through a typical day, that anxiety may be defined as an anxiety disorder.

Separation anxiety disorder sometimes occurs when children are separated from familiar people or places. Symptoms may include worry, refusal to be alone at home, refusal to go to school, or physical symptoms (such as headaches) when faced with leaving a parent or going to school.

Obsessive-compulsive disorder (OCD) is diagnosed when a child has "recurrent obsessions or compulsions . . . that are severe enough to be time consuming . . . or cause marked distress or significant impairment" (DSM-IV).

Children who have persistent thoughts, impulses, or images that are intrusive and inappropriate and that cause marked distress are said to have *obsessions*. Obsessions might include a need to have items or events in a certain order at school or at home or aggressive impulses that cannot be controlled.

Compulsions are repeated behaviors or mental acts (like frequent hand-washing, putting things in order, counting, or repeating words silently) that are done to reduce stress or anxiety. Although OCD usually begins in adolescence or early adulthood, it may begin in childhood. Many children with OCD know that their behaviors are extreme or unnecessary but are unable to stop. They may also have great difficulty trying to identify or explain their feelings.

Post-traumatic stress disorder (PTSD) can develop following an extremely traumatic event or series of events in a child's life, such as witnessing or learning about a death or injury to someone close to the child. The symptoms occur within one month after exposure to the stressful event. Children may show intense fear or helplessness, have difficulty falling asleep, have nightmares, or continually reexperience the event. Young children with PTSD may repeat their experience in daily play activities, or they may lose new skills, such as toilet training or language skills. More children are experiencing PTSD as a result of violence in their lives and in their communities.

Attention Deficit and Disruptive Behavior Disorders

This category includes some of the most common disorders of childhood, including attention deficit hyperactivity disorder (ADHD), conduct disorder, and oppositional-defiant disorder (ODD).

Attention deficit disorder (ADD) and **attention deficit hyperactivity disorder (ADHD)** are characterized by symptoms of inattention that are not consistent with the child's developmental level. ADD or ADHD affect about 3 to 5 percent of school-age children. The essential feature of attention deficit hyperactivity disorder is a persistent pattern of inattention and/or hyperactivity-impulsivity that is more frequent and severe than in other children of the same level of development. Symptoms typically arise early in a child's life. Doctors have written articles about ADHD in early childhood, and some suggest that signs of ADHD can be detected in infancy. Most physicians prefer to wait until a clear pattern emerges of behaviors that affect school or home performance before making a diagnosis. It is important to have a child diagnosed by an experienced professional who can rule out other possible reasons for the behavior.

DSM-IV: Attention-Deficit/Hyperactivity Disorder

A. Either (1) or (2), below:

1. six (or more) of the following symptoms of **Inattention** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Inattention

a. often fails to give close attention to details or makes care less mistakes in schoolwork, work, or other activities

b. often has difficulty sustaining attention in tasks or play activities

c. often does not seem to listen when spoken to directly

d. often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)

e. often has difficulty organizing tasks and activities

f. often avoids, dislikes or is reluctant to do tasks that require sustained mental effort (such as schoolwork or homework)

g. often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)

h. is often easily distracted by extraneous stimuli

i. is often forgetful in daily activities

2. six (or more) of the following symptoms of **hyperactivity-impulsivity** have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level:

Hyperactivity

a. often fidgets with hands or feet or squirms in seat

b. often leaves seat, in classroom or other situations in which remaining seated is expected

c. often runs about or climbs excessively in situations in which it is inappropriate (in adults or adolescents, may be limited to subjective feelings of restlessness)

d. often has difficulty playing or engaging in leisure activities quietly

e. is often "on the go" or often acts as if "driven by a motor"

f. often talks excessively

Impulsivity

g. often blurts out answers before questions have been completed

h. often has difficulty awaiting a turn

i. often interrupts or intrudes on others (e.g., butts into conversations or games)

B. Some hyperactive-impulsive or inattentive symptoms that caused the impairment were present before age 7 years.

C. Some impairment from the symptoms is present in two or more settings (e.g., at school [or work] and at home).

D. There must be clear evidence of a clinically significant impairment in social, academic, or occupational functioning.

E. The symptoms do not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorder, Dissociative Disorder, or a Personality Disorder).

Children with ADHD often have great difficulty completing schoolwork and may give up on school entirely unless they receive assistance. Stimulant medications prescribed by a medical doctor, such as Ritalin or Dexedrine, or a combination of these and other medicines have been very successful in treating ADHD, especially when combined with a positive and reinforcing school and home environment.

Oppositional defiant disorder. The main feature of oppositional defiant disorder (ODD) is a recurrent pattern of negative, defiant, disobedient, and hostile behaviors towards authority figures, lasting for at least six months. The disruptive behaviors of a child or adolescent with ODD are less severe than the behaviors of children or adolescents with conduct disorder, and typically do not include aggression toward people or animals, destruction of property, or a pattern of theft or deceit.

DSM-IV: Oppositional Defiant Disorder

A. A pattern of negativistic, hostile, and defiant behavior, lasting at least 6 months, during which four (or more) of the following are present:

1. often loses temper
2. often argues with adults
3. often actively defies or refuses to comply with adults' request or rules
4. often deliberately annoys people
5. often blames others for his or her mistakes or misbehavior

6. is often touchy or easily annoyed by others
7. is often angry or resentful
8. is often spiteful or vindictive

Note: Consider a criterion met only if the behavior occurs more frequently than is typically observed in individuals of comparable age and developmental level.

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. The behaviors do not occur exclusively during the course of a Psychotic or Mood Disorder.

D. Criteria are not met for Conduct Disorder, and, if the individual is age 18 years or older, criteria are not met for Antisocial Personality Disorder.

Conduct disorder is characterized by persistent behaviors that violate the basic rights of others or that violate major age-appropriate social norms or rules. Children with conduct disorder often have a pattern of staying out late at night despite parental objections, running away from home, or being truant from school. Conduct disorder is often associated with an early onset of sexual behavior, drinking, smoking, and reckless and risk-taking acts. Estimates show it has both genetic and environmental components. Childhood-onset type requires the onset of at least one criterion characteristic of conduct disorder before the age of ten.

DSM-IV: Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-age appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion in the past 6 months:

Aggression to people and animals

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. has been physically cruel to people
5. has been physically cruel to animals

6. has stolen when confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity

Destruction of property

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft

10. has broken into someone else's house, building, or car
11. often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering, forgery)

Serious violations of rules

13. often stays out at night despite parental prohibitions, beginning before age 13 years
14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. is often truant from school, beginning before age 13 years

B. The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

C. If the person is at least 18 years or older, criteria are not met for Antisocial Personality Disorder.

Eating Disorders

Eating disorders include anorexia nervosa and bulimia nervosa, which affect primarily, although not exclusively, adolescent girls. More than 90 percent of both anorexia and bulimia disorders occur in females.

Anorexia nervosa is far more prevalent in industrialized societies, where there is an abundance of food and being attractive is linked to being thin. The onset of anorexia is often associated with a stressful life event, such as leaving home for college. The average age of onset is seventeen years, and research suggests that when it begins earlier (between ages thirteen and eighteen), it may have a better outcome. Women over forty are rarely diagnosed with this disorder.

Anorexia nervosa can be thought of as a "distorted body image" disorder, since many adolescents who have anorexia see themselves as overweight and unattractive even as they appear thin and undernourished to others. A person with anorexia nervosa refuses to maintain a minimally normal body weight, has an intense fear of gaining weight, and exhibits a significant disturbance in body perception. Signs of anorexia nervosa include extremely low body weight, dry skin, hair loss, depression, constipation, low blood pressure, and bizarre behaviors such as hiding food, binge eating and purging, or a preoccupation with food.

Bulimia nervosa is characterized by episodes of "binge and purge" behaviors: eating enormous amounts of food and then going to extreme measures to rid the body of the effects. Most people with bulimia nervosa are within their typical weight range, although some may be slightly underweight or overweight. Features of this disorder include binge eating and inappropriate methods to prevent weight gain. Bulimia nervosa symptoms include the loss of menstruation, fatigue or muscle weakness, gastrointestinal problems, or intolerance of cold weather. Depression may follow a binge-and-purge episode.

Children with bulimia may not have the extreme weight loss of those with anorexia, but they have a similar preoccupation with food and try to hide their intake from family members. They may understand their lack of control over eating and turn to inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.

It is important to have a competent evaluation of an eating disorder to be sure that the food compulsions are not related to another disorder, such as obsessive-compulsive disorder.

Mood Disorders

Mood disorders refer to disturbances of mood that are not due to physical or mental illness. Bipolar disorder (manic depressive disorder) and depressive disorders are examples of mood disorders. They may begin at any age, including infancy. Mood disorders are cyclical in nature, meaning that children have periods of normal feelings and behaviors between episodes of depression or manic-depression; such disorders generally respond well to medications, especially when combined with counseling or psychotherapy.

Depressive disorders are mood disorders that may occur as a single episode, repeated episodes, or alternating with manic episodes.

DSM-IV: Major Depressive Episode

A major depressive episode may exist when :

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

1. depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful).

   Note: In children and adolescents, can be irritable mood.

2. markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. significant weight loss when not dieting, or weight gain (e.g., a change of more than 5 % of body weight in a month), or decrease or increase in appetite nearly every day.

   Note: In children, consider failure to make expected weight gains.

4. insomnia or hypersomnia nearly every day
5. psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. fatigue or loss of energy nearly every day

7. feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
9. recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode...

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Major depressive disorder occurs when a child has a series of two or more major depressive episodes, with at least a two-month interval between them. Depression may look different than parents typically expect, and symptoms may include continuing irritability or inability to get along with others—not just "looking depressed."

For **dysthymic disorder**, a depressed mood must be present for more days than not over a period of at least two years. Dysthymic disorder and major depressive disorder differ based on how severe, chronic, and persistent the problem is. Usually, major depressive disorder is very different from the person's usual functioning, where dysthymic disorder is characterized by chronic, less severe depressive symptoms that have been present for many years.

Bipolar disorder (manic depressive disorder) is a biomedical disorder with symptoms that include an alternating pattern of emotional highs and emotional lows or depression. *Bipolar 1 disorder* is characterized by one or more *manic* episodes (a period of abnormally and persistently elevated, expansive, or irritable mood) or *mixed* episodes (a period lasting at least one week in which the criteria are met both for a manic episode and a depressive episode nearly every day).

There are six sets of diagnostic criteria for various forms of bipolar disorder. Some children have *bipolar disorder, not otherwise specified*, because manic symptoms and depressive symptoms change so rapidly (over days, not months) that they do not meet the duration criteria for a manic episode or a major depressive episode. Included here are the diagnostic criteria for bipolar disorder, single manic episode. Parents who want more information can locate a copy of DSM-IV in their local library.

DSM-IV: Bipolar 1 Disorder, Single Manic Episode

A. Presence of only one Manic Episode, and no past Major Depressive Episodes.

B. The Manic Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.

Pervasive Developmental Disorders (PDD)

Pervasive developmental disorders are a family of severe and pervasive disorders in several areas of development: reciprocal social interaction skills, communication skills, or repetitive patterns of behavior, interests, and activities. PDD can usually be seen in the first years of life and is often associated with some degree of mental retardation. Although terms like "psychosis" and "childhood schizophrenia" have been used to refer to children with PDD, there is considerable evidence to suggest that PDD is not the same as schizophrenia.

Autistic disorder is a pervasive developmental disorder characterized by very abnormal or impaired development in social interaction and communication and restricted activities or interests. Children with autism may fail to develop relationships with peers of the same age and may have no interest in establishing friendships. The impairment in communication (both verbal and nonverbal) can be severe for some children.

Rett's disorder and **childhood disintegrative disorder** are characterized by multiple specific deficits: after a period of normal development, a child begins to lose social and physical skills. With **Asperger's disorder,** children have severe impairment in social interactions combined with restricted and repetitive patterns of behavior, interests, or activities.

Pervasive developmental disorder, not otherwise specified describes children who have a severe and pervasive impairment in social interactions or verbal and nonverbal communication skills, or children who exhibit stereotyped behavior, interests, and activities but do not meet the criteria for other categories of PDD.

Psychotic Disorders

Psychotic disorders, such as schizophrenia and other delusional disorders, are major impairments in thinking or mood in which a child's interpretation of reality is severely abnormal. Psychotic symptoms include delusions, hallucinations, disorganized speech, and grossly disorganized or catatonic behavior.

Schizophrenia is a serious biomedical disorder characterized by loss of contact with environment and personality changes. Hallucinations and delusions, disorganized speech, or catatonic behavior often exist as symptoms of this disorder, which frequently manifests in young adulthood. The symptoms may also occur in younger children. There are a number of types of schizophrenia, including paranoid type, disorganized type, catatonic type, residual type, and undifferentiated type. Schizophrenia is relatively rare.

Selective Mutism

Selective mutism (formerly called elective mutism) occurs when a child or adolescent will not speak in specific social situations, such as at school or with playmates, where speaking is expected, despite speaking in other situations. Selective mutism interferes with a child's educational achievement and social communication. The disorder is not the same thing as failure to speak due to lack of knowledge of, or comfort with, spoken language. It is also not the same as a communication disorder, which may cause a child embarrassment or shame. Selective mutism usually occurs before the age of five but may not be evaluated until a child enters school for the first time. The disorder is relatively rare and usually lasts for a few months, although some children have been known not to speak in school during their entire school career.

Tic Disorders

Four tic disorders that are diagnosed in childhood are Tourette's disorder, chronic motor or vocal tic disorder, transient tic disorder, and tic disorder, not otherwise specified.

Tourette's disorder includes as essential features both "multiple motor tics and one or more vocal tics, which occur many times per day, nearly every day, or intermittently throughout a period of more than one year" (DSM-IV). During this period, the child never experiences a tic-free period of more than three consecutive months.

Chronic motor or vocal tic disorder includes either motor tics or vocal tics, but not both as in Tourette's disorder. *Transient tic disorder* includes either single or multiple motor tics many times a day for at least four weeks, but for no longer than twelve months. This can occur as either a single episode or as recurrent episodes over time. *Tic disorder NOS* is used when the tics do not meet criteria for a specific tic disorder.

Emotionally Disturbed

Severely emotionally disturbed (SED) and **emotionally disturbed (ED)**, are not DSM-IV diagnoses but the terms public schools may use when children need special education and related services because of their behaviors. Many states use a different label, such as *emotional or behavioral disorder* (EBD), *emotional impairment* (EI), or *behavior disorder* (BD) to describe this special education disability category. School professionals may or may not use a DSM-diagnosis as part of this determination, but if state law requires a diagnosis for a child to be eligible for services, it must be provided at no cost to families.

Does My Child Have an Emotional or Behavioral Disorder?

Among all the dilemmas facing a parent of a child with emotional or behavioral problems, the first question may be the most troublesome: Is my child's behavior different enough to need an evaluation by professionals?

Even when a child has problem behaviors, family members may not agree on whether the behaviors are serious. Children who have frequent, severe temper outbursts or who destroy toys, for example, may appear to have a serious problem to some family members, while others see the same behavior as asserting independence or showing leadership skills.

Every child faces emotional difficulties from time to time, as do adults. Feelings of sadness or loss and extremes of emotions are part of growing up. Conflicts between parents and children are also inevitable as children struggle from the "terrible twos" through adolescence to develop their own identities. These are normal changes in behavior due to growth and development. Such problems can be more common in times of change for a family—the death of a grandparent or another family member, a new baby, or a move to the city. These kinds of problems tend to fade on their own or with limited visits to a counselor or other mental health professional as children adjust to the changes in their lives. At other times, however, some children develop inappropriate emotional and behavioral responses to situations in their lives that just do not go away.

The realization that a child's behavior needs professional attention can be painful or frightening to parents. Some parents may think it is their fault if their child has problems. Many are afraid of having their child inappropriately labeled and point out that the array of identifications, medicines, and other therapies stem from opinions of providers who do not know their child. Others note that providers sometimes disagree about a child's needs or how to meet the needs. Still other parents become alarmed after their child has been evaluated and they find out

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that the evaluator believes *they* are the cause of their child's problems. These parents may be referred to parenting classes to fix the problem, even when they have successfully raised other children.

Most parents know that new behavior management skills or communication skills can help them be more consistent and positive. It is simply not useful for providers to continue to blame families for having children who behave differently. Many families have rejected services that might have been useful because they felt blamed, rather than supported, in looking for services.

What to Look For

Before seeking an evaluation, many parents try to help their child by talking to friends, relatives, or professionals at the child's school. Parents try to understand whether others see the same problems in their child's development and to find out what other parents have tried. Some parents know that they need to learn better ways to support their child through difficult times; others sign up for classes that help sharpen behavior skills and teach how to resolve conflicts peacefully. If the child's problems continue after families have done their best to help, the next step is to seek a good evaluation. An evaluation that examines a child's development, behavior, and learning should give parents new ideas about what kinds of services or programs would be useful.

So when is that magical moment when families should recognize that a child's behavior has become alarming enough to need a formal evaluation? There probably isn't one. The gradual awareness that a child's emotional or behavioral development just isn't where it should be eventually sends most parents on a quest for answers.

Perhaps the most important question for parents of school-age children to consider is this: *How much distress do your child's problems cause you, your child, or other members of your family?* If a child is aggressive or argues constantly, or is sad or withdrawn, and these behaviors are a problem for a child or for other members of the family, then the behaviors should be examined, regardless of how severe they seem to be.

While there is no substitute for what parents know about their child, certain guidelines can help families make the decision about when to seek an evaluation. In *Help for Your Child: A Parent's Guide to Mental*

Health Services (Prentice Hall, 1978), Sharon Brehm suggests three criteria to help decide whether a child's behavior is normal or a sign that the youngster needs help:

1. **Duration of the troublesome behavior.** Does it just go on and on with no sign that the child is going to outgrow it and progress to a new stage?

2. **Intensity of the behavior.** Temper tantrums, for example, are normal in almost all children, but some tantrums are so extreme that they frighten families and suggest that something needs to be done. Parents should pay particular attention to their child's feelings of despair or hopelessness; lack of interest in family, friends, school or other activities they once enjoyed; or behaviors that are dangerous to the child or others.

3. **Age of the child.** While some behavior might be quite normal for a child of two, the same behavior may not be acceptable for a five-year-old. Not all children reach the same emotional milestones at the same age, but extreme differences from age-mates in how a child behaves may well be cause for concern.

   Note: Attempts at self-injury, threats of suicide, violent behaviors, or severe withdrawal that makes it impossible to carry on normal routines are emergencies. Parents should seek immediate attention for them, through a mental health or medical clinic, mental health hotline, or crisis center. If you do not know who to contact, start with your family doctor.

You will also want to consider whether your child's behavior could be influenced by other factors:

- a specific physical problem (allergies, hearing problems, changes in medication)
- school problems (trouble with peers, difficulty learning, being teased)
- experimenting with drugs or alcohol
- changes in your family (divorce, a new baby, death)

Young Children

Special consideration needs to be given to identifying behaviors of concern in very young children. Their well-being is so connected with their family that services must be developed with and directed to the family as a unit. A goal in evaluating and providing services to a young child should include helping families understand their own stresses and strengths. Within their families, children first explore their world and learn to adapt to the different demands of life.

Many professionals are not anxious to have a child "labeled and judged" at an early age. On the other hand, the earlier parents and professionals can intervene in the life of a young child who has delays in emotional and behavioral development, the better it is for both the child and the family. Early evaluation and intervention require parents both to give and to receive information about their child's development.

Assessment measures such as intelligence testing are not useful for most preschoolers. Instead, interviews with families and observations of the child help assess how well he or she communicates, plays, relates to peers and adults, and self-regulates behavior. This is probably more useful in deciding whether your child needs professional attention than tests would be.

Most often, the first indications that a baby may have significant problems are delays in normal development. An infant who does not respond to his or her environment should have a thorough evaluation. This includes children who:

- do not show emotion, such as pleasure or fear, that is appropriate for their age
- do not look at or reach for objects within reach
- do not respond to environmental changes such as sound or light
- are overresponsive (easily startled, readily cries)
- have weight loss or inadequate weight gain that is not explained by a physical problem (failure to thrive).

If any of these symptoms concern you, seek a thorough evaluation for your child. If you have questions about your child's development, call your child's pediatrician or family physician. Many doctors who serve young children have materials for parents on normal childhood development.

Toddlers may have a tremendous range of behaviors that may be considered developmentally appropriate, depending on the child's own history. However, any significant delays (six months or more) in language development, motor skills, or cognitive development should be brought to the attention of the child's doctor. These are things your pediatrician or family doctor will want to know about:

- Your child engages in self-stimulating behavior to the exclusion of normal activities.
- Your child is self-abusive (head banging, biting, hitting).
- Your child does not form affectionate relationships with care providers such as baby-sitters or relatives.
- Your child repeatedly hits, bites, kicks or attempts to injure others.

Your child's physician can tell you whether the child needs to be seen by a pediatric mental health professional.

Especially with a first child, parents may feel uneasy, uncomfortable, or even foolish about seeking an evaluation for a very young child. While sorting out problems from developmental stages can be tricky with infants and toddlers, being able to identify these kinds of problems early so that services can be provided can help your child to develop in a healthy way. By carefully observing infants and toddlers as they interact with their caregivers, family, or environment, families or physicians can identify early problems. In fact, many mental health problems cannot be diagnosed in any other way.

The Individuals with Disabilities Education Act (IDEA) requires states to provide services for children ages three through twenty-one who have disabilities and has established an Early Intervention Program (part C of IDEA) to serve infants and toddlers from birth through the age of two. States that receive funds under Part C must provide evaluation of infants and toddlers who have significant delays in development and identify services to meet any identified needs in a written *individualized family services plan* (IFSP).

Parents who have questions about preschool or early intervention programs should call their local school district offices or their state Department of Health or Department of Human Services for guidance.

Cultural Considerations

Appropriate evaluation of your child's mental or emotional status is key to developing appropriate school or mental health services. If your child is from a diverse racial or cultural group, you need to know how, or if, those differences will affect the evaluation results.

Tests, by their very nature, discriminate. If everyone taking a test scored the same, then the test would be of no use. What is important, though, is that tests discriminate only in those areas they were designed to measure—such as depression or anxiety—and not along other measures such as culture, race, or value systems.

If the professional who completes the evaluation is from a different cultural background from your family or child, you can ask what his or her experiences are in cross-cultural assessment or services. Professionals who are sensitive to bias related to language, socioeconomic status, or culture in formal assessment tools will willingly share such information with you.

One way of minimizing cultural bias in evaluation is to use a multidisciplinary approach, involving people from different backgrounds (teacher, therapist, parent, social worker) in the assessments. Here are several questions to consider:

- Do all the providers agree on the child's needs?
- Did the professionals use your family information about your child's functioning at home and in the community to complete the evaluation?
- Do you believe the results of the evaluation are accurate?

When a multidisciplinary approach is not practical or available, the evaluator should give a variety of tests to reduce the effects of bias in any individual test.

If children from specific ethnic or cultural groups are overrepresented in services that have been selected or recommended for your child, you will need to carefully examine how the decision was made.

If you decide that the decision was not influenced by bias, you will be more confident about the value of the program selected for your child.

Seeking Evaluation

If your child or adolescent has behaviors that you'd like assessed by a mental health professional, where can you turn for an evaluation?

For school-age children, a first step could be to request an evaluation through the special education director. If you do not want to involve the school at this point, you have several other options.

A family doctor can rule out physical health concerns and refer families to a child psychologist or psychiatrist. Many hospitals and most community mental health centers also offer comprehensive diagnostic and evaluation programs for children and adolescents.

Evaluation can be costly, but some supports are available for families. For instance, most insurance covers all or a portion of evaluation costs, or Medicaid (Medical Assistance) may cover the costs for eligible families.

For children who are eligible for Medicaid, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides preventive health care, including screening (evaluation), diagnosis, and appropriate mental health services.

EPSDT screening offers a comprehensive health evaluation, including emotional health. Your child is entitled to periodic screenings, or an interperiodic screening (between normal screening times), whenever a physical or emotional problem is suspected. Children in this program are entitled to health services that address such problems from any Medicaid provider, public or private. Because of the continuing changes in Medicaid and differences from state to state, it is a good idea to check with the state Medicaid office if you are concerned about services under the EPSDT program. (See pages 118-121 for a list of state Medicaid offices.)

If you live in a rural area, you may first want to approach your county's public health nurse or mental health services director. Either may be able to direct you to an evaluation program in your area.

Community mental health centers can also help and can be less expensive than a private doctor or mental health provider. Ask for staff with experience in evaluating the mental health needs of children. Community mental health centers are required to provide services to children and adolescents, but there is no specific requirement that their providers have specialized training to work with children and youth. If in doubt, ask for the credentials and expertise of the person who is assigned to work with your child or family. Providers should display their credentials in their workplace and be willing to discuss them.

If you believe that your child needs to be seen by a professional of a certain race, sex, or culture, you need to communicate this request early in the process of locating help.

What Types of Professionals Provide Mental Health Services?

Many types of professionals provide mental health services to children. Different professionals look at emotional or behavioral disorders in different ways. Their training and personal philosophy shapes their outlook and their recommendations for services.

You can think about the kinds of services your child needs in several different ways. One approach is to seek services that focus just on your child and his or her needs. If your child's problems are not disruptive to your family and you are able to provide consistent support at home, then providing services to your child alone may be appropriate.

If your child's behaviors or emotional state affect other children, school performance, or your family as a whole, you probably want to find services and supports for the entire family. Raising a child with emotional problems can be exhausting for many families, and supports such as respite care or behavior programs may be not only helpful but necessary.

This chapter describes a representative sampling of licensed providers and the kinds of services they offer. Be aware, though, that mental health services are only one part of an overall program of services and supports a family may need.

Psychiatrists

Psychiatrists are medical doctors who specialize in treating mental and emotional disorders. Psychiatrists complete four years of medical school as well as additional years of specialized training in psychiatry—the study, diagnosis, and treatment of mental illness or emotional disorders. Psychiatrists who specialize in working with children and adolescents must complete additional training. Since they are licensed physicians, psychiatrists can prescribe medications to treat specific disorders. They may also provide therapy and, when necessary, request related medical testing such as brain scans, endocrine testing, or blood analysis when a medical cause is suspected for a child's problems.

Behavioral Pediatricians

Behavioral pediatricians are medical doctors who specialize in treating the behavioral and emotional problems of children. While behavioral pediatricians are highly skilled medical doctors, not all have had specific psychiatric training. It is wise for parents to ask whether their behavioral pediatrician works in cooperation with a child psychiatrist, unless the pediatrician has had specific additional training to understand and treat mental health disorders in children.

Psychologists

Psychologists complete studies in human behavior. They are qualified to evaluate a child's mental health status and to provide psychological counseling. Psychologists have two to four years of graduate school and often several years of additional training in a clinic or private practice setting under the supervision of a licensed psychologist. Psychologists do not have a medical degree and cannot prescribe medicines.

When selecting a psychologist, ask about credentials. A diploma from the American Board of Professional Psychology is earned by practicing for five years in private practice and then passing a specific test. Other credentials may include membership in the American Psychological Association, state or local licenses (requirements vary widely between states), or certification in a specialty area such as clinical psychology, counseling, or psychoanalysis. A master's degree or additional training in psychotherapeutic interventions may be required for private practice in some states. Most states require a Ph.D. for psychologists in private practice. A licensed psychologist has a master's degree and a state license. A licensed clinical psychologist should have a Ph.D. as well as a state license.

A school psychologist is defined by the National Association of School Psychologists as a mental health professional who works in the school. A school psychologist has studied behavior and mental processes and has been trained to work with behavioral concerns in the schools. School psychologists also administer and interpret academic, behavioral, and aptitude tests. Most states license school psychologists and generally require a master's degree. If the state you live in does not, you will want to ask about specific coursework that has been required. A school psychologist should be able to state his or her competencies to a parent who asks about specific skills. You may also want to ask whether the school psychologist has a National Certification for School Psychologists. This information will help you to determine whether your child's school psychologist has the skills to meet your child's evaluation or counseling needs. You may also inquire with the state agency, such as the state Psychological Association, that maintains such information.

Psychiatric or Clinical Social Workers

Psychiatric or clinical social workers are trained as therapists to evaluate, counsel, and arrange for care of people with special medical or psychological needs. Both psychiatric and clinical social workers have received training to provide services to individuals and families under stress; psychiatric social workers specialize in working with people with emotional disorders and their families.

Credentials you can ask for include accreditation by the Academy of Certified Social Workers (ACSW), which requires passing a written examination and working for two years under the supervision of another mental health professional. Also look for membership in professional organizations, such as the National Association of Social Workers. Social workers in private practice in Minnesota and most other states should have a master's degree in social work (MSW) and may have additional training in psychotherapy. Psychiatric social workers must have an MSW, and many hold doctoral degrees in social work.

School Social Workers

School social workers may conduct counseling sessions with children, organize and run a variety of groups within the school, or coordinate efforts that bring together the child, his or her family, school personnel, and other important people in the child's life. As a rule, school social workers do not have the extensive training of clinical or psychiatric social workers, although they may have great practical experience in working with children and their families. Social workers in public school systems may be responsible for home visits, setting up school meetings, or being the primary contact person for a family within a school setting, in addition to their other duties.

Psychiatric Nurses

Psychiatric nurses are registered nurses (RNs) who have taken further studies in psychiatry. They often work closely with a psychiatrist, supplementing direct psychiatric services, but may also work under the direction of a physician who is not a psychiatrist. Psychiatric nurses are becoming an important resource for families in managed care mental health systems, where insurance benefits are controlled by such entities as health maintenance organizations (HMOs), rather than through private insurance companies. In such systems, the role of psychiatrists is becoming increasingly restricted to evaluation, medication management, and consultation with other service providers.

Marriage and Family Therapists

Marriage and family therapy is an emerging field for professionals who focus on helping families to develop healthier responses to stress and specific strategies to use in solving their own problems. The educational backgrounds of marriage and family therapists may range from bachelor's degrees with post-graduate training, to degrees in social work, psychology, or family therapy. Some therapists may even have a medical degree. Parents who are looking for a family therapist should look for someone who has a master's degree (at minimum) and who has membership in professional organizations such as the American Association for Marriage and Family Therapy. Although not required by all states, a license in family therapy or graduation from a special program in family therapy is highly recommended so you can be sure the therapist you select has the knowledge to help your family.

Pastoral Counselors

Some clergy who provide private therapy with children, adults, and families are known as pastoral counselors. Some pastoral counselors have graduate degrees in psychology, social work, or family therapy. Families should look for certification from the American Association of Pastoral Counselors and a local license, or affiliation in organizations such as the American Association of Marriage and Family Therapists, the National Association of Social Workers, or the American Psychological Association.

Special Education Teachers

Special education teachers who work with children who have emotional or behavior issues should have specific training in developing structured and supportive behavior plans, and in helping other teachers use strategies. Their special role is described in chapter 8, "What Services Should Schools Provide?"

The severe shortage of qualified teachers for children with emotional disabilities continues, so it is especially important to ask what training the teacher has had or is currently receiving to meet the needs of your child. In Minnesota, teachers of children with emotional disorders are required to be licensed in that area or to be enrolled in a training program that leads to the specialty licensure.

Behavior Analysts

Behavior analysts are trained to determine why a child behaves as he or she does. A behavior analyst or other qualified person conducts a functional behavioral assessment to understand how your child's unique biology and temperament and the stresses in the environment work together to create a climate in which problem behaviors occur.

Functional behavioral assessment is generally conducted by school personnel. A number of different kinds of professionals may conduct a functional behavioral assessment with children, particularly psychologists, special education teachers, or social workers. Ideally, the professional will have a degree in behavioral analysis, but that is not required.

Sometimes schools compile a list of all the problem behaviors a child has had over a period of time and call that a "behavioral assessment." If the document collects information but does not analyze what events in the environment support problem behaviors and does not recommend positive approaches to helping a child to change problem behaviors, then it is not a functional behavioral assessment.

Other Providers

Many other types of professionals who provide services to children and families use assorted titles. At the first meeting with a provider or staff at a mental health facility, you will want to find out about the qualifications of the people who will be working with your child. You make the final judgment about whether the staff has the qualifications to help your child.

Sometimes it is tempting to favor providers who have the most academic degrees hanging on their walls. One director of a large residential treatment center says that he does not hire on the basis of degrees but looks for people with compassion, empathy, and proven experience in working with children and families. For instance, many traditional healers and respected elders are important resources for helping the children of their communities grow up healthy. Their successes with children are based on a unique cultural perspective that is learned in communities, not colleges.

If you are considering a mental health agency that has a large number of new staff, be sure to ask if key staff plan to remain with the agency during the course of your child's services. You may also need to know how much supervision will be provided to your child's therapist, counselor, or family support specialist, as well as well as how much individual support will be provided to your child and family.

Medicines

An important question to consider when deciding on a program for a child involves medicine. Drug therapy is a very popular treatment for some children or adolescents with emotional disorders. Medication can promote dramatic improvements in some children, especially when combined with counseling or an appropriate behavioral and family support program. If medicine is recommended by your child's physician following an evaluation, you must decide whether or not to try it with your child. Since many medicines currently in use have not been approved by the Food and Drug Administration for children under age twelve, it is important that you understand the potential risks and benefits so you can make an informed decision.

Parents concerned about their child's response to medicines are entitled to have their questions answered fully. Here are some concerns:

1. Does my child really need to take medicine, or are there other alternatives we can try?
2. What are the potential side effects of the medicines? Are they short-term effects, or can they have a lasting impact on my child? Do the side effects outweigh the benefits? Pharmacists can usually supply a printout of a specific medicine, its recommended use, and potential side effects. However, be sure to discuss the medicine with the physician who prescribes it.
3. What alternative medicines can be tried if the one we decide to try first does not work or has severe side effects?
4. How long will it take to know if the medicine is helpful or if the dose is correct?
5. What happens if my child forgets to take the medicine? Will it be harmful if my child often forgets to take the medicine?
6. Do I need to keep a record that will help the doctor know if the medicine is effective?
7. How often will the doctor check to see if the medicine works?
8. What should I do if my child refuses to take the medicine?

Some professionals recommend minimal use of medicines, believing long-term improvements depend on changing behaviors and attitudes. Many parents and professionals, though, find medicines to be a useful part of a child's overall plan. Medicine is especially effective in the treatment of attention deficit hyperactivity disorder, bedwetting, anxiety disorders, major depressive disorder, and schizophrenia.

Parents who believe that medicine should be considered for their child need to find a program or services connected to a psychiatrist or a pediatrician. Parents who have strong beliefs—either for or against the use of medicine—should discuss the issue thoroughly with the child's service provider before their child begins a program.

How Do I Select a Mental Health Provider?

Your vision of mental health services that are effective for your child and family may be very different from that of the person who provides services. This is particularly true if the service provider does not include families in deciding what supports and services they need. Many parents have become knowledgeable and effective advocates and will not accept services they believe are not respectful of their child and family.

Traditional mental health providers whose training has often defined families as the cause of a child's problems may have a difficult time accepting your expertise in determining what services you want and need for your own child and family. The notion of traditional child and family therapy being provided by an expert has undergone a radical change. Although therapy may be one service that families say they need, most families agree that they also need information, support, and services that they determine are helpful. Effective mental health services empower families, not blame them, and should include access to information and community resources. The role of a counselor or therapist is not to treat, cure, or change you, but to provide a relationship your family can use for personal growth. Therapy or counseling services should help you and your child clarify issues for yourselves in three specific areas:

1. **Who am I?** Helping your child and family understand yourselves and why you do what you do
2. **What do I want?** Helping your child and family decide what you want to change and set goals
3. **How can I get there?** Providing practical assistance to help your child and family to meet your goals

Helping you meet your family goals may mean that the provider refers you to an array of resources and services that have not been traditionally considered mental health services. This might include providing or helping you locate respite care, family support, or recreational and social programs for your child. Because an increasing body of evidence suggests that children can be effectively served in their own homes and communities when families are a part of service design and delivery, the role of children's mental health counselors has expanded to become more of a partner with the family.

It is important to select a provider based on the needs of your child and family, particularly if you are seeking family counseling. To locate an effective provider:

- Ask friends who have used a counselor.
- Call your local mental health clinic or agency.
- Ask your family doctor.
- Check with your church or synagogue.
- Call your insurance company administrator.

Determining the quality of the provider you select is difficult, but effective people generally have good reputations. If you are not satisfied with your choice, let that person know.

Families have the right to choose whether or not to use a particular mental health professional. At times, families in public systems may be assigned a mental health worker based on availability. Sometimes parents are told that they may not change the worker without the permission of the agency or provider. However, it is important that you agree that the provider's expertise, philosophy, and personality meet your needs.

As you make decisions about your relationship with the person who will be working with you and your family, remember this: Counseling or therapy is basically an examination of ideas, feelings, and behaviors. You may, at times, feel under the microscope as you work to help your child. While no parent needs to accept blame or criticism from a professional, there may be times of "uncomfortableness" as you begin to examine family roles and behaviors. Even though there may be medical reasons that help explain why your child behaves as he or she does, positive outcomes for children are strongly related to a supportive environment. In other words, providing more or different structure at home, using different communication techniques, developing a more supportive behavior program at home or at school, or reducing stress may be important changes that need to be made to help your child learn new behavioral skills. A good mental health provider can help you with these areas.

There are some definite red flags to notice when deciding whether a therapist is right for your family. Pay particular attention when:

- You feel disrespected, labeled, or ignored.
- You feel pushed into accepting a particular label or conforming to a particular philosophy.
- You feel pressured to use or to discontinue medication against your wishes.
- You feel blamed.

If you are not comfortable in your relationship with your provider either for your child or yourself, you should discuss this with the provider. If you remain uncomfortable following an honest discussion, then you may need a change in providers. If the services are offered by a public agency that will not allow you to change providers, request that the agency give you, in writing, the reason for that decision. If you still disagree, you have the right to appeal the decision in writing. Ask for written information on their appeal process—and use it!

One Family's Experiences

My husband and I have two daughters, both of whom required counseling at different times in their lives. The following two experiences illustrate very different attitudes about counseling and about our role in that process as family members. These experiences taught me that parents and counselors need to agree on their roles and on how and when progress will be reviewed for a child receiving services. Which experience do you think we preferred?

First Experience: The psychologist met with my husband and me about our teen-age daughter for about five minutes at the scheduled first session and spent the rest of the time with our daughter, Pam. We were told that occasionally he would need to meet with us regarding Pam's progress. At the family sessions, the psychologist gave us the impression that he believed everything our daughter told him as the truth; in contrast, he did not seem to believe what the rest of the family had to say. My daughter later said that she just "set the stage, and watched the drama unfold." In other words, she enjoyed that the psychologist listened to her but not to us. As parents, we felt we had no opportunity to have input into our daughter's program. While the counselor was not deliberately disrespectful, the process certainly was.

Second Experience: The psychologist met with our daughter and the rest of the family separately at first, then brought us together to talk about what each of us wanted to gain from counseling and to develop a plan that was acceptable to all. She proposed that at the next session, she would do an assessment of Pam. It was agreed that Pam would attend one-hour sessions weekly for five weeks, and that the family would attend the sixth weekly session, where we, the therapist, and our daughter would agree on whether progress was being made. At the sixth session, the psychologist met with Pam and us separately, to find out how we felt about whether our daughter was making progress. The psychologist listened carefully to our separate reports, then met with us in a group to share her own impressions about where we were. Together, as a team, we made the decision to continue with counseling.

The philosophy behind how services are provided can either strengthen families by supporting their expertise in helping their child, or further isolate them from the services their child needs. Parents who disagree with the approach suggested by their mental health professional should not hesitate to seek a second opinion.

Families may want to interview a provider before making a decision about whether he or she is right for their family. The first meeting can be set up as a two-way interview. The provider will ask many questions about the child and family to set up an effective treatment plan. Family members will ask questions to decide if they have found the right person for their family's needs. Here are some suggestions about what to ask in making a decision about a counselor for your child:

What is your philosophy about how my child developed his or her problems? Services stem from the professional's philosophy. Families should be sure they agree with the professional's attitude and beliefs about emotional or behavioral disorders before undertaking a specific program of therapy or counseling.

What is your training and educational background? Is the mental health provider licensed? Does he or she have specific experience or training in working with children? Does the provider have experience in working with children from a specific cultural or racial background or with children who have similar problems?

How will we set goals and what is my role in helping to plan services? Are families integrally involved in planning services, or are they considered unimportant to the child's treatment? Who defines a child's needs and determines what services are needed? What happens if parents and providers disagree on services? Families must take the lead to let providers know what their expectations are for themselves and their children.

How long will the services last? Will the provider meet with parents to agree on specific, measurable outcomes? How will parents know if the services are effective for their child? How much information will parents be given about any private sessions their child may have with the provider? What kinds of information will remain confidential between the child and the mental health provider?

You have a right to information about your child's progress, and much of that information is not confidential. While a therapist cannot be expected to tell you what your child has said in confidence, too often parents report that their only role is to pay the bills, and that no information about progress is shared with them.

Bill of Therapy Rights

This is not a legal bill of rights, but a statement of what you can reasonably expect from a therapist. You have the right:

1. To ask questions at any time.
2. To know if a therapist is available to see you or how long the waiting period would be.
3. To be fully informed of the person's qualifications to practice, including training and credentials, years of experience, and so forth.
4. To be fully informed about the therapist's therapeutic orientation.
5. To be fully informed regarding the therapist's areas of specialization and limitations.
6. To ask questions about issues relevant to your therapy.
7. To be fully informed of the limits of confidentiality in the therapy setting.
8. To be fully informed of the extent of written or taped records of therapy and their accessibility.
9. To specify or negotiate therapeutic goals and to re-negotiate when necessary.
10. To be fully informed regarding fees for therapy and method of payment, including insurance reimbursement.
11. To refuse any intervention or treatment strategy.
12. To discuss any aspect of your therapy with others outside the therapy situation, including consulting with another therapist.
13. To require the therapist to send a written report regarding services rendered to a qualified therapist or organization on your written authorization.
14. To give or refuse to give permission for the therapist to use aspects of your case for a presentation or publication.
15. To know the ethics code to which the therapist adheres.
16. To solicit help from the ethics committee of the appropriate professional organization in the event of doubt or grievance regarding the therapist's conduct.
17. To terminate therapy at any time.

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What Are Some of the Different Philosophies and Therapies?

There are a number of different kinds of mental health services that can be provided to children and their families, and each has its own strengths. The following therapies may be used alone or in conjunction with other community-based services for your child and family. This list offers brief descriptions of some different approaches to the treatment of emotional and behavioral disorders.

Psychotherapy

Psychotherapy is a broad term for treatments in which the goal is to change a child's personality, rather than just the child's outward behavior.

In **psychoanalysis**, the therapist attempts to bring an unconscious conflict to the patient's awareness and then help the patient deal with the conflict. The cause of the child's problems is assumed to be psychological issues that can be uncovered and addressed through psychoanalysis.

A **psychodynamic** approach to a child's problems is geared to changing the way children think or feel about themselves to help them change their behavior. Treatment would rely on talk therapy (individual talk sessions with a therapist), art therapy, or play therapy (particularly when children are very young or have limited verbal skills), to help children understand their emotions.

Interpersonal therapy is based on a belief that problems arise from difficulties the child has in relating to other people. Individual counseling combined with group sessions help children understand their present relationships and learn how to establish new and more satisfactory ones.

Behavioral Therapy

Rather than focusing on a problem's origin and seeking to change personality, **behavioral therapy** concentrates on a child's behavior and seeks to help the child change the aspects that are inappropriate or produce negative results. Behavioral therapy is also used to help build positive or desirable behaviors. Typically, these programs take less time than psychotherapy. They focus on understanding the behavioral interactions between a child and his or her environment.

In the behavioral approach, problems are believed to occur because a child has received reinforcement for problem behavior. (For example, a child might receive the attention he wants only when he is very naughty.) This approach assumes that all behaviors are learned and focuses on teaching children new behavior skills that are more acceptable.

The behaviorist changes the pattern of rewards and punishments your child receives so that behavior will change. Behaviorists examine a child's behavior in a variety of environments. They try to modify the environment to help a child maintain better control. The focus is not on an internal "cause" of emotional or behavioral problems but on bringing about positive changes in a child's behavior. Parents must be closely involved in implementing a total behavioral program for their child and attend some or all sessions with their child. They also may learn better behavior support techniques to use at home.

Cognitive Therapy and Social Skills Training

Cognitive therapy teaches problem-solving skills and self-instructional strategies (either in groups or individually) to modify a child's behavioral and emotional responses.

Many children with emotional or behavioral problems lack skills in basic social know-how, both with peers and adults. **Social skills training** teaches children to interpret cues in their environment (body language, verbal interactions) so they can interact appropriately.

Ecological Treatment

An **ecological approach** to services reflects a belief that children are part of a larger community (their family, their class at school, their neighborhood friends) that must be understood and often restructured to encourage growth. Services include working with all the important people in the child's group where the problem occurs, not just with the parent or family. An ecological approach focuses on helping a child and family with current issues, not past events. Family counseling or training, which assumes that families can bring about positive changes in behavior, is an ecological treatment model.

Family systems therapy examines family interactions and combines a behavioral and psychodynamic approach to help families improve how the members relate to one another. In family systems therapy, a therapist or counselor may give "assignments" to family members to help correct a family problem. For example, some parents might be asked to listen for five minutes without interrupting when their child is speaking.

Medical Treatment

Children treated under a **medical** or **biological model** are diagnosed as having a specific illness or symptom pattern that might be corrected medically, with medication or treatment. A treatment program involves medical providers such as a psychiatrist, a pediatric neurologist, or a pediatrician.

Medical programs are the treatment type most likely to be covered by insurance or Medicaid, because they relate to a diagnosis by a medical specialist and are conducted or supervised by medical personnel. These services are often connected to hospitals or clinics.

Less likely to be eligible for coverage are programs conducted by nonmedical personnel. Medicaid, however, may cover mental health professionals, including licensed psychologists, if the child they are treating has a specific medical problem, including a mental health diagnosis.

Treatments based on a medical model may use medications or drug therapies. The treatment focuses on helping a child recover from an illness, not on examining family structure and pattern of behavior as a possible cause of the problem. However, many children diagnosed under a medical model also respond to positive behavioral interventions as part of a program, and families may play a role in restructuring a child's inappropriate behavior by learning new behavior management techniques.

Counseling and Therapy Programs

Counseling or **therapy programs** for children can take several forms. For instance, a child might meet individually with a therapist or counselor to talk about issues. Young children might engage in **play therapy** to help them express feelings and conflicts through play situations. A family might be asked to meet with a counselor to address any problems with family relationships that are affecting the child. **Parent effectiveness training** may help families learn skills to improve their relationships and deal with their child, regardless of the particular model under which the child is diagnosed. Children may have positive behavior plans through schools or their mental health providers that reward and thereby increase positive behaviors. Finally, a child might meet in a group session with other children who are experiencing similar emotional or behavioral problems.

Family-Centered Programs

In the examples just described, teams of physicians, psychologists, social workers, educators, and parents may be involved and working together. Many of the approaches are frequently used in combination. For example, a child who takes medication may also benefit from play therapy.

The most recent and most effective approaches to helping families whose children have emotional disorders are family-centered; that is, the family and child are at the center of services, which revolve around, and support, the family unit. Nonmedical services, such as respite care, crisis nurseries, or recreational programs, that support and strengthen families of children with serious emotional or behavioral disorders are an essential part of a total mental health program for many children.

Parents Helping Parents

Some parents, after careful consideration, determine that their family functions well despite their child's issues. These families may feel that how they relate to their children has not been the cause of problems for their child. They may understand that the cause of their child's problems is unknown but not related to family relationships. Other parents may see that events in their child's life affected the development of an emotional or behavioral disorder; still others may believe that they are responsible for their child's emotional or behavioral problems.

Regardless of a parent's personal experiences or beliefs, many find that sharing information about their child with other parents is affirming and helpful. Such parents may wish to seek out a self-help or support group. This kind of group may help parents and families cope with their children's problems and keep stress at a minimum. It also provides them the information they need to work with systems serving their child. Support groups, which are generally run by parents for parents, focus not on the cause of a child's problems, but on providing support and information from a family perspective that helps families survive difficult times.

Parents in Minnesota who are interested in participating in a support or self-help group may call PACER Center for information on available groups or for advice and assistance in organizing a new group. The number is (952) 838-9000. Minnesota parents outside the Metro area may call toll-free (800) 537-2237. Parents from outside Minnesota may call PACER's national toll-free number, (888) 248-0822, or the Federation of Families for Children's Mental Health, (703) 684-7710, for information on activities in their individual states.

What Kinds of Services Should I Consider?

For many years children have been placed in unnecessarily restrictive settings to receive mental health services. Community-based models for children's mental health services have been virtually nonexistent. There have been no early intervention services for most of these children, and little encouragement for their parents.

When the children's problems become so severe that their families are unable to keep them at home, the children may be placed in hospital or residential treatment facilities, sometimes located far from the child's family home. Although a few children may require residential programs to address serious emotional disorders, research shows that with appropriate community-based care, most children can be served in their own homes and neighborhoods.

The concept of serving children where they live has great appeal, but many barriers to doing so exist. Obstacles include professional attitudes about families, rigid funding patterns, the lack of collaboration among community agencies, and the inflexibility of private insurance funding for newer models of care as alternatives to residential treatment. Although many states and communities have begun to provide mental health services to children in the context of their families and communities, funding patterns to pay for such services have been slower to change.

The Wraparound Process

Communities with a broad variety of medical and nonmedical mental health and support services may deliver these services through a process known as wraparound. The term **wraparound** actually refers to the process and not to a set of services. An array of community-based services follow the child, "wrapping around" the child and family in their own home, school settings, or community programs. Services are developed by a team that includes people who have a personal interest in the child. The idea of developing flexible services dictated by the needs of the family sounds simple, yet implementation requires that the entire community come together to plan how such services should be directed and funded.

Families and providers together must advocate for increased collaboration between all community agencies in developing services for children. They must be prepared to speak out for the wraparound process to gain acceptance in their community.

Ideally Wraparound Should Be:

Interagency:	Collaboration must exist at state and community levels.
Family-focused:	A child cannot be treated in isolation of environment or family.
Unconditional:	Policies must be in place so that participating providers do not reject children or families.
Community-based:	Services must be available in the community of the child and family.
Individualized:	Tailor-made plans should fit the needs of the child and family.
Strengths-based:	Services are built on what children and families know.
Culturally competent:	Services utilize the strengths of race and ethnicity.
Cost effective:	Services avoid duplication.
Outcome driven:	Services have outcome measures to ensure that children improve as a result of community-based services.

The wraparound process provides parents a voice in directing services to their family. It encourages ownership in the process by securing their agreement to their child's program. The model gathers a community team of providers, teachers, parents, friends, relatives, and others who are invested in the child's wellbeing.

The key to success is parent participation. Parents, in collaboration with a mental health provider, case manager, or other facilitator, choose the wraparound team members. The complete team then meets to assess the child's and family's strengths and needs, determine what needs are priority, and drafts a plan for how services will be provided. Parents have the right to refuse a service they determine does not benefit their child or family.

What follows is a general introduction to some of the kinds of mental health services available to children and their families. Although not every community has all these services in place, parents who do not know what to ask for can begin to learn about the options. It is important that parents request the services their child and family need; services may not exist without advocacy.

Outpatient Treatment and Counseling Services

The most commonly used and therefore most readily available interventions are individual, group, or family therapy. These services may be provided by community mental health clinics, child guidance centers, or private outpatient clinics, or through private mental health practices. Outpatient mental health care practitioners include psychiatrists, psychologists, clinical social workers, psychiatric nurses, and mental health counselors. Outpatient counseling or therapy may be provided daily, weekly, or monthly, depending on need, and is often used in conjunction with other treatments (medicine, school program, etc.). Examples of outpatient services include individual or group therapy or counseling, parent training on behavioral management, and medicine management.

Home-Based Services

Local or county mental health centers can help parents and families access home-based services. They can also create services in response to the needs of families. Home-based services are designed to prevent out-of-home placements for children in crisis. They represent a significant departure from traditional mental health services in several respects. Home-based services tend to be intense and brief, lasting several weeks to several months. They are provided to children and families in their homes during the hours families normally spend together. The focus is on teaching families new ways of resolving problems to prevent future crises and to prevent out-of-home placement for children with emotional disorders.

Most successful home-based programs offer twenty-four-hour crisis services. Counselors, who generally work in teams, provide in-home crisis intervention to help families resolve problems when their child's behaviors are most intense. With the parent, they assess child and family needs and provide training in behavior management techniques, communication, assertiveness training, and problem-solving skills. The team may also assist the family with home management skills or help them locate other necessary resources such as medical, legal, advocacy, or support services.

For a home-based program to work, the therapists, counselors, or social workers must approach the problems a child is experiencing from the family's strengths, rather than focusing on the deficits. This also means that families are vital participants in determining the services they need to help support their child. Shared decision making can be difficult for professionals who have been trained to see themselves as the "experts" in determining what a family needs and how it should be provided. That attitude may erode or destroy the usefulness of home-based services because the family's help in implementing the plan is vital to its success.

Home-based intervention services are not designed to eliminate the need for other types of mental health services, including residential care. However, they can help ensure that children who can benefit from less restrictive settings are not placed in residential care unnecessarily. Even children who ultimately do need residential placement should have had the opportunity to try less restrictive alternatives first.

Day Treatment

Day treatment programs for children with serious emotional disorders (sometimes called partial hospitalization programs when provided in a hospital setting) provide integrated educational and mental health services. Day treatment is often used as a follow-up to residential placement, but it may also be used as a community alternative to residential placement.

Day treatment programs are designed to help children and adolescents develop positive behavioral skills, learn to deal with their emotional problems, and relate well to others. Services should include academic instruction, as well as individual and group counseling and crisis intervention. Most programs have a strong family participation component; some require that parents participate in family therapy. For adolescents, long-term day treatment services should also include training in work-related skills, such as vocational curriculums, supported work programs, or job exploration. Day treatment programs typically have a small student-teacher ratio to ensure that children have access to an adult if they need it. Day treatment models range from three to five hours per day, five days a week, including during summer months.

Parents considering day treatment for their child should ask about the philosophy and program rules before choosing a program. While most day treatment programs focus on the needs of the children and adolescents in their charge, some assume that the child's problems originate in "family dynamics" and discharge the child if the parent refuses to participate in family therapy or misses too many sessions.

Certainly it is reasonable to expect parents to be as involved as possible in helping their child to become more emotionally healthy. Family services that support the self-identified needs of parents and caretakers are integral to any coordinated services. However, blanket policies requiring "family therapy" as a condition of placement do not illustrate current understanding about the biological basis of many emotional disorders. These practices should be questioned when not appropriate to the needs of the child. In some cases, parents may need to appeal restrictive admissions practices to the state-level agency that oversees such programs.

Traditionally, day treatment programs for children and adolescents have been provided in community mental health or hospital settings. Recent programs have focused on bringing the needed mental health services into school environments, not only to facilitate re-entry into regular school programming, but also to provide more opportunity for normal educational activities for children who participate.

Residential Programs

Historically, residential programs were available as acute psychiatric inpatient care in psychiatric hospitals, psychiatric units in regular hospitals, or placement in a regional treatment center or state hospital for long-term care. These programs still exist and are generally reserved for children who can no longer function in their own homes because of an emotional disorder. Residential treatment centers may focus on behavior modification programs, intensive therapy, medicine management, specialized diets, or on any other treatment philosophy.

Community-based residential programs such as group homes may be offered for a child whose therapy needs are less intense than those provided in medical settings but who still requires a fully structured living environment. Group homes may provide educational services on-site. More often, the child or adolescent is transported to a public school program for that portion of the day. Treatment in a group home includes evaluation, psychotherapy or counseling, and behavior modification.

Children may be recommended for out-of-home placement for a variety of reasons, including assessment and diagnosis, crisis intervention, psychiatric treatment, abuse prevention, or education.

Parents should understand the type of program their child may be entering. They should know the treatment philosophy and goals of the recommended placement, the anticipated or average length of stay, what costs, if any, the family will be expected to assume, and the criteria for the child's return to the family home. In addition, if the family does not believe their child requires the intensity of services delivered in a residential setting, it is important to speak out at the planning meeting about the possibility of alternative community-based services.

Transfer of Legal Custody: Parents Need to Know

Because few families can afford the costs of residential programming, parents may find themselves turning to a county or state agency for assistance. In Minnesota, a county agency may file a CHIPS petition (Children in Need of Protection or Services) in order to obtain a court's directive to provide services, especially when the service recommended is residential treatment. Other states have similar petitions, which are commonly used in child protection cases where removal of a child from his or her family home is done to ensure the child's safety or treatment. However, it was not the intent of the legislation governing such petitions to deny rights to those parents who simply need assistance with funding services for their child.

Parents must use extreme caution when seeking an out-of-home placement. In some states, parents must relinquish custody or have their child declared a "ward of the court" to obtain necessary mental health services. This represents one of the greatest advocacy challenges for parents and professionals alike.

Although there are no federal requirements that parents give up custody, in many states this practice is common. Even in states such as Minnesota that do not require families to transfer legal custody of their children, many counties still insist that parents give up their rights in order to receive county funding assistance.

For information on custody relinquishment, or to lend a voice in support of legislation abolishing this practice as a condition for accessing needed services, contact the Research and Training Center on Children's Mental Health, at the Regional Research Institute, in Portland, Oregon, at (503) 725-4040. Or call the Federation of Families for Children's Mental Health at (703) 684-7710. For assistance within an individual state, parents may locate their Mental Health Law Project through state Legal Aid offices.

An out-of-home placement is not a quick-fix for a child or adolescent who is experiencing an emotional crisis. Generally, such placements occur only after other, less restrictive interventions have been tried unsuccessfully. As states have increased their community-based alternatives to residential treatment, families whose children are urgently in need of such placement are finding that their community or county has placed a moratorium on referrals. If a child urgently needs residential treatment and less restrictive alternatives have been tried without success, parents may have to become vocal advocates for that service. They will need an evaluation that clearly identifies their child's need for a secure environment. They must also be prepared to use the appeal process of their health plan or the placing agency.

Treatment Foster Care

Another out-of-home arrangement for service might be provided through specialized foster care. Parents who are unable to handle the extreme behaviors of their child in their own home can seek to place the youngster in a treatment foster home. Their county mental health system or state human services or social services department can help with this.

At times, especially when other children in the family home are at risk, placement in another home gives both the child and the family a needed break. In this arrangement, the child may receive professional help for his or her emotional problem while remaining in a "home" environment and attending a community school or day treatment program. Foster care providers for children with serious emotional or behavioral problems should have specific training in behavioral intervention and crisis management techniques. In some states, homes where foster parents have received such training are called therapeutic or treatment foster homes. Some treatment foster care programs have the capacity to provide emergency respite care for parents of children with mental health or behavioral needs.

Placement in a therapeutic foster home cannot take place unless a mental health case manager or social services representative believes there is a documented and genuine need for the child to leave his or her parental home. Also, before a youngster is placed in foster care, appropriate family based interventions should have been attempted to help the child to remain at home. If those services are not successful and residential treatment is seen as a possibility, therapeutic foster care is an alternative to consider in keeping children close to their families and in their communities.

If temporary foster care placement is being considered for a child with an emotional or behavioral disorder, parents will want to find out more about the expected relationships between parents and foster parents. This is a critical time in a child's life, and parents and foster parents need to work together. As a team they can ensure that the child receives appropriate care and services, and plan the child's transition between the foster family and the permanent parents or caretakers when the child is ready to return home.

Shelter Care

Shelter care placement for children and adolescents is a temporary residential service available in many communities. A shelter placement may be a short stay with a trained family in the community or a stay of one or two days to a month or more in a group home or agency facility. Shelter care provides temporary care to youngsters who cannot remain at home because of an emotional crisis or abuse or neglect. Adolescents who have run away from home may also receive services in a temporary shelter care facility while plans are made for their return home.

Shelter care is not a therapeutic placement but a temporary safe place for children and adolescents to stay until their immediate crises can be resolved.

Crisis Nursery

A **crisis nursery** accepts children, generally from birth to age five, for very short term placement, usually no longer than several days. Parents who are too stressed to have their children at home may use a crisis nursery to prevent the possibility of neglect or abuse. Because crisis nursery care is among the newer family support services, it may not be routinely available in all areas. However, the availability of crisis care for difficult-to-manage babies, toddlers, and young children should be advocated for as a requirement in all communities, to keep children safe and to provide their families with brief, necessary breaks in the stressful routine of caring for a difficult child.

Family Community Support Services

Family community support services are an array of services provided to children with emotional and behavioral disabilities and their families in their own communities. Medicine monitoring, parenting classes, behavior management classes, support groups, recreation services, and respite care are examples of services that can be provided to families to enhance their ability to care for their child at home. Raising a child with an emotional or behavioral problem is always frustrating and sometimes impossible without help. Family community support services are designed to ease some of the daily stresses so that the child can remain at home. Compared to out-of-home placement, these services are an economical and critical addition to children's mental health services.

Care Coordination

While not a mental health service per se, **care coordination** can be essential in providing unified services. Care coordination includes locating and accessing services for individual children and youth, advocating for children and their families within the many systems that provide services, overseeing the development and implementation of an adequate treatment plan, reviewing progress, and coordinating services across agencies. Ideally, care coordination provides "whatever it takes" to families in terms of time, resources, and support to ensure that children make appropriate progress and remain with their families whenever possible. The status of care coordination across the nation currently ranges from nonexistent in some areas to barely adequate in others.

Respite Care

Respite care also is not technically a mental health service as it is not directly therapeutic to a child. Respite care—temporary child care that offers relief to the child's caregivers—is the service most families say they need in order to keep their child at home. Caring for a child with serious emotional or behavioral concerns is highly stressful. Many parents report that they are unable to leave their child with a sitter or relatives, that day care centers will not accept the child, and that it is not safe for the child to be home alone. Occasional periods of respite can significantly reduce stress in the family and enhance their ability to keep the child in the family home.

Respite care can take many forms. Care may be provided in the family home, allowing parents to get away for a few hours, or in the respite provider's home. In some cases, group homes or other residential facilities may provide overnight or weekend care.

Most states make respite care available to parents of children with physical or developmental disabilities, but it has not routinely been offered to parents whose children have emotional problems. Because there are no credential requirements for respite providers, parents may want to ensure that a potential respite worker has appropriate training to handle the emotional, social, and behavioral needs of their child. In advocating for respite care, families should insist that it be provided not just as an emergency response to a child's out-of-control behavior, but as a planned "break" in family routines for the purpose of relieving the normal stresses faced by families with a troubled child.

In some states, parents have joined together to set up their own respite care programs. The advantage of parent-run programs is that families have an understanding of their children that is invaluable in training respite care providers to develop skills appropriate to the level of need.

Other families form child-care cooperatives to help relieve the strain of daily care for children with severe problems. Since children with emotional and behavioral disorders may not be understood or accepted by adults who are not familiar with their problems, parents can be reassured in knowing that their respite provider also has a child with similar needs.

Educational Services

Public schools must provide special education and related services for children from age 3 through 21 who meet federal and state criteria. (States may choose to serve older or younger children as well.) Even if a child with an emotional or behavioral disorder does not qualify for special education and related services, schools may provide accommodations to enhance the educational program for youngsters with emotional or behavioral needs. The right to these accommodations is guaranteed under another federal law, Section 504 of the Rehabilitation Act of 1973.

Schools present a unique set of challenges for children with emotional or behavioral disorders. District discipline policies, school rules and standards, absenteeism rules, transportation requirements, and the sheer size of many schools make it difficult for some children to succeed in regular school environments. In specialized environments or in special schools, students may receive the individual assistance they need but lack any positive peer role models. Parents should become familiar with their child's rights and responsibilities in public education so that they can become effective partners in developing services. (A broad overview of special education is presented in chapter 8, "What Services Do Schools Provide?")

Comprehensive Children's Mental Health Act

In 1984, the Child and Adolescent Service System Program (CASSP) provided states with a philosophical model for the development of community-based, coordinated services for children with serious emotional disorders. (See pages 122-125 for an excerpt of the model.)

The philosophy behind the model is respect for the child and his or her family and respect for their right to receive services in their own community, in the same way services are provided for other chronic illnesses.

Minnesota's Comprehensive Children's Mental Health Act (CCMHA) was passed in 1989. Based on the CASSP philosophy, the Act requires that mental health services for children be available statewide. The intent and spirit of the law was to create a mental health system for children that is child-oriented, family-centered, and flexible enough to meet their needs. Counties are required to implement coordination, service, and advocacy mechanisms to ensure that the system is integrated and coordinated with all child-serving systems at the state, local, and individual case levels.

Twelve specific services are required under the Minnesota Comprehensive Children's Mental Health Act:

- education
- early identification and intervention
- emergency and crisis services
- case management (care coordination)
- home-based services
- outpatient counseling
- day treatment services
- therapeutic foster care
- acute care
- screening
- residential treatment
- family community support services

The state and counties both are required to implement advisory groups to advocate for the mental health needs of children. The state-level advocacy body is the Minnesota State Subcommittee on Children's Mental Health. At the county level, the Local Advisory Council is charged with identifying the unmet mental health needs of children residing within the county and reporting those needs to the county board. This committee requires the participation of consumers, parents, advocates, and service providers and offers parents and families an opportunity to participate in developing the emerging system of care for children. Even if the parent positions on the Local Advisory Council are filled, parents and family members may still attend the meetings to gather and share information.

are filled, parents and family members may still attend the meetings to gather and share information.

Minnesota now provides funding for counties to develop Children's Mental Health Collaboratives. A Collaborative is a group of agencies, advocates, and parents who jointly meet to develop services for children. Services are flexible and based on the needs expressed by families. A community team of people, chosen by the parents helps identify the strengths of children and their families, and develops a plan of services that is based on the strengths of families. Minnesota's Children's Mental Health Collaboratives provide services using a wraparound philosophy.

For more information on the CCMHA and Children's Mental Health Collaboratives, or to obtain a copy of the Act, call the Minnesota Department of Mental Health, at (651) 296-4497, or access it online at *www.revisor.leg.state.mn.us/stats/245/* and view sections 245.487 through 245.4888.

What Services Should Schools Provide?

Individuals with Disabilities Education Act

The 1997 Individuals with Disabilities Education Act (IDEA) and its regulations specify the special education and related services school districts must provide for students with disabilities. The federal law guarantees children with disabilities access to an appropriate educational program and provides them and their parents specific due process rights. This chapter highlights some of the important sections of federal special education law.

Special Education and Related Services

Special education under the Individuals with Disabilities Education Act (IDEA) means specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability. These services are provided by qualified education staff, such as special education teachers, psychologists, or social workers. An example would be specialized instruction by a licensed teacher.

Related services are "transportation and such developmental, corrective, or other supportive services . . . as may be required to assist a child with a disability to benefit from special education. . . ." Related services include speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment, counseling services, including rehabilitation counseling, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in school, and parent counseling and training. For children and adolescents with emotional or behavior disorders, a potential related service would be counseling or therapy.

SED Definition

Under IDEA, children with emotional or behavioral disorders receive services under the special education category *seriously emotionally disturbed* (SED) or *emotionally disturbed* (ED). States may choose to use a different label, such as *emotional or behavioral disorder* (EBD) *emotionally impaired* (EI), or *behaviorally disordered* (BD), instead of ED. However, eligibility for services is based on the following federal definition:

"The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, that adversely affects educational performance:

- An inability to learn that cannot be explained by intellectual, sensory, or health factors.
- An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- Inappropriate types of behavior or feelings under normal circumstances.
- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance." (IDEA 300.7(a)4)

Children may receive special education services under ED if they meet the federal definition or the definition established by their state's Department of Education. Many mental health professionals also use the term ED to describe children with specific mental health diagnoses. However, a child with a diagnosis from a psychiatrist, psychologist, or neurologist is not necessarily eligible for special education services, unless he or she also meets the federal special education definition.

Evaluation

If parents believe their child may need special education and related services, the first step is to request, **in writing**, that the school district conduct a multidisciplinary evaluation.

The evaluation must be completed by a multidisciplinary team—professionals from different backgrounds (psychologists, teachers, therapists, etc.)—at no cost to parents. Professionals observe the child in various school settings and administer specific tests to determine needs and strengths. Parents also participate by sharing information on how their child functions at home and in the community, as well as providing any medical information relevant to school planning.

The evaluation is key to the development of an individualized education program (IEP), since the findings of the evaluation will determine whether a student needs special education services. If the child is eligible, it will also be used to develop the goals and objectives and related services that make up the IEP, and determine a child's need for accommodations.

Parents will want to read the results of their child's evaluation. They will need to consider whether they agree or disagree with the testing and the conclusions of the evaluation team. Most school districts hold a meeting to go over the assessment results and decide whether a child is eligible for special education services. Parents will compare the results of the evaluation with what they know about their child. If they agree that the evaluation is correct, the results will be used to decide whether the child needs special education and related services. If parents do not agree with the result of the evaluation, they have several options:

1. They may request in writing that the school district conduct additional testing.
2. They may have the child evaluated elsewhere at their own expense.
3. They may request that an independent educational evaluation (IEE) be conducted by nondistrict personnel, at no cost to them.

Schools must refer and pay for an IEE if parents *disagree in writing* with the district's assessment. If the district is unwilling to pay for an IEE, it must show, at a due process hearing, that its assessment is appropriate. The district must either pay for the IEE or initiate a hearing.

The Individualized Education Program

An individualized education program (IEP) is a written program designed to meet the specific needs of a child.

An IEP is developed by a team that includes the child's parents, the child's regular education and special education teachers, a representative of the school district, a person who can interpret the evaluation, and other individuals with knowledge about the child and his or her needs.

An IEP must contain:

1. The present levels of educational performance (how a child is doing at the time of testing). This includes information about how a child's disability affects involvement and progress in regular classes and regular studies.
2. Measurable annual goals and short-term objectives or benchmarks related to meeting the child's educational needs.
3. Special education and related services, supplementary aids and services, and program modifications or supports to school staff so the child can meet the goals.
4. An explanation of the extent, if any, a child will not participate in the regular class and regular activities.
5. A statement of any modifications needed to participate in state or districtwide assessments, or, if the assessment is not appropriate, why, and how the child will be assessed.
6. Date services are to begin and the frequency, location, and duration of the services
7. A statement of how progress will be measured, including how parents will be informed of progress and if the progress is sufficient to meet the goals.

The IEP must also include, for youth who are 14 or younger, a statement of the student's transition service needs. By the time a youth is 16, the IEP must include any needed transition services.

The IEP meeting takes place after the assessment has been completed and the results compiled. The meeting should be scheduled at a time that is convenient for parents. If parents are unable to attend at the scheduled time, they may request that the meeting be rescheduled.

School Rules and Policies

There are few areas more contentious than student discipline. On one hand, schools are responsible for insuring that all students have a safe and appropriate learning environment. On the other hand, children with emotional disorders are often held to disciplinary standards that are inappropriate for their disability or particular diagnosis. It is particularly important for parents and schools to decide at the IEP meeting what behavior expectations are reasonable for the child and to include in the IEP any changes in school rules or expectations the team agrees are needed. If no changes in district, school, or classroom discipline policies are specifically stated on the IEP, the child may be held to the regular discipline policies.

Accommodations in Regular and Special Education

Many children with emotional or behavior disorders spend at least part of their school day in a regular education classroom setting. Most require some modification of the environment, teaching strategies, or coursework. These modifications must be listed in the child's IEP.

For instance, a youngster with an acute anxiety disorder may need special encouragement to come to school. A reasonable plan might be to offer the student partial credit just for attending school. The student might benefit from a pass/fail grading system rather than the standard system. In this instance, the IEP might state, "A pass/fail grading system will be used in all academic classes."

If a child is able to attend school and learn in the regular classroom but, because of an emotional disorder, may not be able to complete the regular work, the program should be adapted to provide an opportunity for success. The curriculum can be modified or replaced with individualized assignments related to the course.

A youth with severe attention or memory problems may not be able to listen to a class lecture and simultaneously take notes. In that case, a photocopy of the teacher's lecture notes or another student's notes could be provided without penalty to use as a study guide. Providing two sets of textbooks, one for home and one for school, can help teach responsibility without penalizing the student for forgetting to bring books home. A print copy of materials presented on the board or over-head insures that youngsters who have difficulty copying have the materials available for study. The IEP accommodation should reflect what the team agrees is needed.

A simple, clearly written behavior plan in a regular classroom—one parents, teachers, and the student agree is reasonable—should be developed *before* problems arise for some students. Because parents and schools might not always agree on what constitutes a disruption, this area should be thoroughly discussed at the time the plan is developed. A behavior plan is generally included in or attached to the IEP.

Suspensions and Expulsions

Repeated short-term suspensions remain one of the most widely used behavioral interventions for youngsters who have emotional or behavioral disorders. Most suspensions are for offenses such as violating school or classroom rules. If their child is unable to adhere to the regular school discipline plan, parents may want to have the IEP team consider the circumstances under which suspension should be used.

If suspensions are used for disruptive or rule-violating behavior, parents should ensure that the opportunity to develop skills in those areas is part of their child's IEP. Children who are not specifically taught replacement behaviors will not learn appropriate behaviors simply by being removed from school.

If a child is suspended for more than 10 school days in a school year, the IEP team is required to conduct a functional behavioral assessment to determine why the behavior is occurring and to develop positive ways to address the behavior. The school must also provide services whenever suspension exceeds 10 school days in a school year. Services must be sufficient for the child to continue to make progress in meeting IEP goals and to make progress in the general curriculum.

Public schools are responsible for the safety and security of all students, regardless of whether they are receiving special education services. If a child's actions are considered to create an immediate and substantial endangerment to other students, the building administrator has the right to suspend a student for up to ten school days to ensure the safety of the child or others.

A child may be removed from his or her current placement by a school administrator and placed in an appropriate interim alternative educational setting for up to 45 days under certain circumstances that involve drugs or weapons at school or at a school function. A due process hearing officer can also order a 45 day removal if the school is able to show at a hearing that a child's behavior is substantially likely to result in harm to self or others.

Parents will want to request an IEP meeting whenever their child is suspended from school and to ask the team to consider whether the behavior that resulted in suspension is related to the child's disability. This is called a manifestation determination review. It is required in the event of a 45-day removal, but parents should ask that the team hold the review anytime they believe their child is being suspended for behaviors that are part of his or her disability.

Evaluating the IEP

After the IEP meeting has been completed, the agreed-upon goals and objectives are written and the IEP is given or mailed to the parents. At this point, many parents do a final check before agreeing or disagreeing with the proposed program.

The purpose for developing IEP goals and objectives from evaluation information is to provide an opportunity for a child to make reasonable progress in areas of weakness so that he or she can be successful. A successful special education experience is measured by the progress a child or adolescent makes in achieving the goals and objectives on his or her individualized education program.

An IEP must be written once a year and reviewed at least once during the year. It may also be reviewed any time parents or teachers believe the review is needed. Parents who want to be included in the review meeting should notify the school that they want to be invited to attend.

An IEP can form the basis for a successful school program for children and adolescents with emotional or behavioral disorders. When an IEP is developed in conjunction with parents and the mental health and education professionals who work with their child, it defines the support and structure the student needs, as well as the approach to be used in providing educational services.

Section 504 of the Rehabilitation Act

In addition to the specific rights provided to students and their parents under IDEA, parents need to be aware of the provisions of another federal law. Section 504 of the Rehabilitation Act of 1973 is broader than IDEA in that it applies to any agency that may provide services, not just schools. Section 504 simply prohibits discrimination against anyone solely on the basis of a disability, in any program or activity receiving federal funds. Section 504 states:

> no qualified handicapped person shall, on the basis of handicap, be excluded from the participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives benefits from Federal financial assistance. *[34 CFR 104.3 (a)]*

A qualified handicapped person under Section 504 is a student who:

1. has a physical or mental impairment that substantially limits one or more major life activities (caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working);
2. has a record of such an impairment; or
3. is regarded as having such an impairment.

To guarantee that students are treated fairly, the school should develop a Section 504 plan or accommodation plan that outlines the modifications or other accommodations the student requires in regular or special education. A school district is responsible for implementing any accommodations that the 504 team sees as necessary.

If a child is evaluated for special education services and found ineligible, parents should request that the school's Section 504 coordinator meet with them to discuss their child's eligibility for accommodations under that law. If a student has not been evaluated and is not believed to be eligible for special education services, a parent may request that a Section 504 evaluation be conducted to determine whether their child needs specific accommodations.

Here are examples of possible accommodations under Section 504:

1. An elementary school student is denied a field trip with his classmates because of disruptive behaviors that have been identified as part of his disability. A reasonable accommodation would be to hire a behavioral specialist or behavioral management aide to go on the field trip to assist him.

2. A high school student with attention deficit disorder receives failing grades because she does not have enough time to finish classroom assignments. A reasonable accommodation would be either to shorten assignments or to provide extra time, without penalty, for her to complete assignments.
3. A student with bipolar disorder does well when his medicine is at appropriate levels. His medicine was changed during the school year, causing him to be lethargic. He was unable to keep up with his schoolwork, nearly failing required subjects. He was removed from the high school soccer team because he did not meet the required minimum grades. An accommodation for this student could be to convene a team to establish that the medicine change resulted in the lowered grades. The Section 504 team could waive or amend the grade requirement for soccer participation, and, if needed, modify the requirements for future classes when medicine changes occur.

Parent involvement in special education planning can mean the difference between a successful educational experience and an unsuccessful one. As difficult as educational planning can be for a child, in twenty years, when teachers and administrators have forgotten the names of the children whose lives they touched, children will remember their educational experiences.

Sometimes parents feel they need a break from planning, even educational planning, because they are too tired, too frustrated, or too angry to continue. Everyone needs a break at times. But parents should never give up their efforts to secure the best possible educational experience for their child, for they will live a lifetime with the results. If parents need help, they may call the Parent Training and Information Center in their state for information and assistance; the list of Centers is in the appendix. See pages 109–117.

For a more in-depth discussion of educational rights, PACER offers two publications: *What Help Can I Expect From the School District for My Child with an Emotional or Behavioral Disorder?* is an overview of special education services and what parents should expect from their schools. *Honorable Intentions: A Parent's Guide to Educational Planning for Children with Emotional or Behavioral Disorders* covers aspects of educational planning, including behavioral interventions, adaptations and modifications, and prereferral interventions. The book focuses on understanding how and why behaviors occur so positive strategies can be developed to help children learn new behavioral skills.

Financial Considerations

One of the most frustrating aspects of seeking appropriate mental health services for children is finding programs families can afford. Few programs or services are free, unless a state or county agency has taken custody of a child. Even then, fees are often assessed against parents who have no decision-making authority about the services their child receives. Unless parents have extensive private funds or an unusually comprehensive insurance policy, they must locate other financial resources. Because each person's financial situation, each insurance policy, and each treatment program's eligibility criteria are different, no universal answers apply to each specific situation. It is important for parents to learn as much as possible about mental health coverage under plans offered in their state. They should also learn what government agency handles appeals if their child is denied coverage for a service covered under their health care plan.

Fifteen years ago, most U.S. families received health care on a fee-for-service basis through indemnity insurers. They went to a doctor, who charged a fee, which was then reimbursed by their insurance company.

This system of medical insurance has largely been replaced, however, with a managed care system. Managed care came about as one solution to the pressures to contain medical costs. Under a managed care system, the insurer determines who will be served, what services will be provided, and how much the plan will pay providers for each service.

Managed care plans develop standards to evaluate the services provided. They contract with medical providers for an agreed-upon fee, and the providers' profits then depend on being able to provide medical services at costs below the fee. If a doctor or clinic makes use of more expensive services than the limits agreed to, the provider shows a loss. If they save money on a per-patient basis, they earn profits. Some managed care contractors provide bonuses to their providers for saving money, which can create an incentive not to provide expensive necessary services. In this instance, higher profits can be earned by providing fewer services. Now fully 85 percent of the nation receives health coverage through some type of managed care plan.

Health Maintenance Organizations (HMOs)

Health maintenance organizations, or HMOs, are a prepaid type of insurance plan. The monthly insurance premium to the HMO pays for all services covered under the plan, so enrollees receive no unexpected medical bills. The tradeoff is that HMO members must use only physicians and clinics that have agreed to provide services through the HMO. HMOs generally use primary care physicians who see patients and determine whether they need a specialist for further treatment, including treatment for an emotional or behavioral disorder.

There are a variety of models of HMO prepaid health care. An HMO may contract with a group practice where the physicians work for the group rather than the HMO. The group then receives a per-person fee each month for each enrolled member, regardless of the frequency or intensity of services needed by an individual. Or the HMO may contract directly with a private physician to provide services, using a negotiated fee schedule. Another alternative is for the HMO to employ a staff of physicians to provide services only to members of the HMO.

Patients often have to pay partial fees for some medical expenses, such as prescriptions, or nominal fees for emergency-room visits. HMOs are regulated by a state agency, which reviews written complaints about insurance coverage. The agency governing HMOs in Minnesota is the Department of Health, at (612) 282-5600.

Preferred Provider Organizations (PPOs)

Preferred provider organizations, or PPOs, are another type of managed care. Patients receive a list of physicians or clinics that are "preferred providers." Enrollees pay less when they use the providers on the list, but they are free to seek services from providers not on the list if they are willing to pay more.

Managed Behavioral Health Care

The reasoning behind managed care systems is that it is less expensive to provide preventive health care than it is to deliver more costly services for a higher level of need. However, because preventive services have rarely been provided for children at risk of developing emotional problems, it remains to be seen how those mental health services will look, if they even exist.

Managed care services are based primarily on medical approaches to need. The Child and Adolescent Service System Program (CASSP) philosophy, by contrast, envisioned a full array of medical and non-medical community-based services. Families need to be aware that even when managed care companies limit access to expensive services such as residential treatment, more appropriate community-based alternatives may not be available. This is especially true of nonmedical services such as respite care, recreational services, and some kinds of in-home family services. Yet these are the services that may reduce, or eliminate for some children, the need for residential treatment.

Many families are concerned that providers over-rely on medication to control children's behaviors instead of providing more costly counseling and other therapeutic services. Families who object to the use of medicine for an emotional or behavioral problem or who do not believe that medicine is appropriate for their child must be diligent in expressing those concerns to their insurer. They also must know and use their insurer's appeal process if services do not meet the needs of their child and their family.

On the positive side, managed care, which has as a primary focus the early intervention in health and mental health disorders, has the potential to strengthen and expand community-based services begun under the CASSP initiative. The kinds of services that need to be available in this model include both medical and nonmedical services ranging from respite care and family support programs to day treatment and other clinical mental health services. In recent years, states and local communities have made progress in developing such "systems of care" for children and adolescents, and initial evaluations of such services are beginning to demonstrate the benefits of this approach.

How managed behavioral health care develops in individual states will depend, to a large extent, on the input of providers and recipients of services. A number of committees and boards in every state are considering how managed health care systems might work and determining what kinds of children's mental health services need to be included in managed care plans.

When families of children with emotional or behavioral disorders help develop behavioral health care systems in their state, appropriate mental health services are more likely to be included in their health care plans. Children's mental health services are a relatively new addition to basic health care services, and community-based services are an even more recent phenomenon. If parents are not part of the team that develops managed care requirements, it is likely that these new services may not exist in an overall health care plan.

To learn more about the potential role of family members, parents should contact their State Mental Health representative for Children and Youth (SMHRCY), in their Department of Mental Health.

Group Insurance Policies

Group health policies provide at least a limited amount of mental health coverage. Generally, they partially cover the costs of treatment through a hospital program, a community mental health center, a psychiatrist, or a licensed consulting psychologist. Many policies do not have provisions for newer services such as respite care, in-home family services, or recreational programs for children, although some of these services may be covered in the future.

Policies written for individuals (nongroup coverage) vary a great deal; parents should carefully examine their specific provisions. The advantage of a private individual or group policy is that families have a wider range of providers to choose from than under other plans. Such freedom of choice, however, is not inexpensive.

In a typical "fee for service" model provided under group or individual insurance policies, families may choose any physician or clinic they desire. The insurance policy covers some or all of the fees charged by the providers and relies on the provider's discretion as to whether the medical services provided are necessary. To discourage the use of some expensive services, many insurance companies attach requirements to health care plans, such as copayments for out-of-pocket costs above the monthly premium, deductibles, and excess costs. Most also limit the amount of coverage a family member can use in one year; many have lifetime caps on services, especially mental health services. Many plans also exclude specific disorders from coverage.

Minnesota Law

Minnesota law requires all group policies sold in that state to provide mental health coverage. All newly issued or renewed group health care plans must provide equality of benefits between mental health services and physical health services. What this means for parents in Minnesota is that their insurance carrier cannot charge higher deductibles or co-payments for mental health services than it charges for physical health services. Lifetime limits on mental health services are allowed only to the extent that the same limits apply to physical health care.

Every state will have agencies that oversee a variety of insurance plans. Families can consult the yellow pages for state offices, or call the general state information number and ask which regulatory office is responsible for the kind of health care plan the family has.

Even though parents may know they have insurance coverage, in general, the therapy or treatment program being considered for their child should be reviewed to make sure it is eligible for mental health coverage. A rule of thumb is that the more medically oriented a mental health program is, the more likely its eligibility for coverage. Parents may find that many of the newer models of community-based services aren't covered under their family insurance policy.

No matter what type of insurance coverage a family chooses, it will be important to read the section on mental health coverage carefully. It is also a good idea for parents to learn the appeal process for their policy if they feel their child is being denied necessary mental health services. Insurance carriers are able to direct families to the formal appeal process, as well as to let them know where to file a complaint about services.

Community Mental Health Programs

Many parents with limited resources may find the mental health program offered by their county or local government a good source in seeking services for a child with an emotional or behavioral disorder.

Community mental health centers must meet the mental health needs of all persons in their area, including the needs of children and families. Counseling and other therapeutic interventions for children and families (art or music therapy, parenting skills classes, individual and group therapy) are available in many community mental health centers in most states. In seeking services from a community mental health center, parents should request that their child be seen by a licensed child mental health specialist or a professional with significant expertise and experience in working with children and their families.

Medicaid—(Medical Assistance or MA)

What if a family's income is too high for government income assistance, but too low to handle the cost of medical care for a child with an emotional disorder? Families might want to find out if their child could qualify not for an income assistance program but for Medical Assistance (Medicaid or MA) to help handle the costs of necessary treatment. Though it is the child's costs that are a concern, it is the parent's income that counts when determining eligibility. Families may inquire into the possibility of Medicaid by calling their county human or social services departments, or their state's Medicaid agency.

TEFRA: Section 134 of the Tax Equity and Fiscal Responsibility Act of 1982 (the Medicaid Waiver). Another way of qualifying for Medicaid in some states when the parents' income is too high to qualify for MA is to apply for Medicaid under TEFRA. For a child to be eligible for Medicaid assistance under TEFRA, a child must:

- be under the age of eighteen,
- be eligible for MA if he or she was in a medical institution, and
- need the kind of home care comparable to that provided in a medical institution.

The cost to MA cannot exceed the cost of institutional care. Parents of children who qualify under the Medicaid waiver will often pay a fee based on their income to help cover the cost of services.

TEFRA is one model of providing MA eligibility to children; other states will have differing sets of regulations. Parents who need financial assistance but whose children do not qualify for Medicaid because of parental income should call their Medicaid office and inquire about their eligibility under TEFRA. A list of state Medicaid offices are in Appendix E of this book.

What kinds of programs are covered under Medical Assistance? The general guideline is those most medically oriented, that is, most hospital-based programs, some community mental health programs, and services from private doctors. The types of programs eligible are periodically reviewed and reassessed. Courts are reexamining the eligibility of certain programs, and the federal administration has granted certain waivers that allow some programs, including schools, to receive Medicaid reimbursement for services.

Families should also note that one of the ways in which states are attempting to manage health care costs without federal policy is by applying managed care principles to Medicaid. By providing services to Medicaid-eligible individuals and families through HMOs, states hope to limit the soaring increase in medical costs. Managed care HMOs would apply a "medical necessity" standard for all services. Medical necessity, however, may be determined by the managed care company, not necessarily by the family's physician. Managed care Medicaid is a reality in some states, such as Minnesota, and is under development in others.

Supplemental Security Income (SSI)

In 1985, the category of childhood mental disorders was incorporated into the list of impairments eligible to receive Supplemental Security Income benefits. In 1990, the U.S. Supreme Court broadened the standard of impairment for children who are poor and have disabilities by adopting a functional definition that paralleled the adult definition. The Court said that if a child's impairment has a significant impact on the child's normal daily activities and the family has met income guidelines, they could be eligible for Supplemental Security Income (SSI) benefits.

In 1996, however, the new welfare reform act was enacted. One of its provisions changed the SSI definition of disability for children. The new and stricter definition states that a child's impairment is considered disabling only if can be medically proven and causes "marked and severe functional limitations" that will last for at least 12 months or end in death.

The new eligibility rules define severity for a child's functional limitations as either "marked" limitations in at least two areas of functioning (such as social functioning and personal functioning) or "extreme" limitations in one area of functioning, such as inability to walk.

As a result of the new law, many of the approximately 965,000 children who were receiving SSI in 1996 were no longer eligible for monthly benefits. Most of the children affected by the new definition of disability included those with mental and emotional impairments, such as less severe learning disabilities and behavioral disorders.

To find out if their child may qualify for SSI benefits, parents can request application forms from their social worker, mental health worker, or case manager. They may also call their state's Social Security Administration office.

What Can Families Do to Help?

Finding Support

Although the number of children in America identified as having emotional or behavioral disorders has increased, most children growing up today remain reasonably well-adjusted and successful at home and at school. Parents may take great pride in their children's accomplishments and in their ability to raise successful children. This is as it should be.

However, a frequent message to families—from schools, grandparents, communities, and other parents—is that "good" families raise "good" children. It's an almost universal belief that parents are responsible for how their children understand and relate to the world.

The problem with this idea, though, is that many perfectly fine parents have children whose behaviors, by any standard, are unacceptable. These parents are often blamed—by other families, teachers, and the professionals who work with their children—for not providing the structure, limits, discipline, or supports that seem to work well for most children. Worse, they often blame themselves for not being able to control their child.

As one mother reported, "I've been told by my son's psychiatrist that I am a terrific parent for my son who has oppositional defiant disorder and I really believe I'm doing a good job. But, whenever my son has a major blow-up, I still wonder what I'm doing wrong, what I should have done differently. When my son has a tantrum in the grocery store or in church, other parents look at me like I'm hopelessly inept, and a part of me accepts that I just do not know anything about being a parent."

Policies and politics that isolate families from the accumulated wisdom of other parents have contributed to the problem, as have "helping systems," which are generally crisis oriented. Being a parent is exhausting work, even when children do not have emotional problems. No one is born with all the skills necessary to handle every problem, yet too often, when parents do ask for help for their children, they are turned down until the family's problems become too severe to ignore.

All parents need information, encouragement, training, and support to raise healthy children. The proliferation of self-help and support groups in all areas of parenting attests to the need for parents to come together to share information, support one another, and seek solutions to a variety of child-rearing questions. For years, the stigma of having a child with an emotional or behavioral disorder or mental illness has kept these parents from participating, or even being welcomed, in "regular" parenting groups.

Emotional and behavioral disorders and mental illnesses occur across all income ranges, educational levels, and ethnic groups. Children with emotional or behavioral problems may live in single-parent homes or two-parent families; with adoptive or foster families; in suburbs, rural communities, or cities.

Despite differences in child-rearing practices, culture, race, or socioeconomic status, most families have a great deal in common. Parents may share similar frustrations in the exhausting and sometimes unsuccessful search for appropriate and affordable services, as well as the sense of helplessness in knowing that their child's needs are not being met. All parents of children with emotional and behavioral disorders need accurate information about therapeutic and educational services for their child. They also need support and advocacy to help them and their family cope with the impact of raising their child. Families share an enduring love for their children, even (or especially) for those who are rejected by others as unlovable.

Like all parents, parents of children with emotional and behavioral disorders may respond from time to time to the needs of their child in ways that are not helpful. Unlike other parents, however, their occasional unhelpful responses are often held up as examples of how they have failed their children. As parents become increasingly ostracized from supports, they may exist like little "islands" in their own communities, cut off by their child's behaviors from day care programs, the neighbor's swimming pool, Sunday school programs, a visit to Grandma's, park and recreation programs, and other social activities. Access to the full range of normal community services is simply not available to many families of children with emotional and behavioral disorders.

Unsupported, families who deeply love their children may be unable to maintain them within the family home or community, and many seek out-of-home placement to ensure the survival of their child and the rest of the family. Families who are able to locate information, access to services, and providers who respect their expertise remain the best source of stability and support for their child. Parents who obtain appropriate services, as well as recognition and support for their own role, often become tireless advocates to improve the mental health care system for all children.

Today, in many states, parents of children with emotional disorders or behavioral differences are creating new support networks for sharing information and advice. In these networks, parents find unconditional support for their role as parents and as advocates for their children. Most groups are parent-run; many parents want the opportunity to meet with one another without feeling that they are being "supervised" by professionals. Other groups are organized and run by mental health providers as part of their efforts to provide community support to families.

If parents cannot find a group to their liking, they may want to think about starting one themselves. Assistance in starting and running a support or advocacy group is available from many sources. Parents may call PACER Center for a referral.

What Parents Can Do

One major role many parents assume is to locate and coordinate the services provided to their child. In an ideal system, professionals from many agencies (schools, mental health, community corrections, health, etc.) exchange information on what is happening with a particular child and what each agency might do to support the effort of the others. Some states and local communities do have interagency agreements that bring together service providers from a variety of agencies to coordinate and fund individualized services. Such coordination is not routinely available, however, and in states where it does exist, only the most severely affected children are likely to receive coordinated services.

Realistically, many parents must assume responsibility for coordinating services and for insisting that less restrictive alternatives to hospitalization or residential treatment be available to their child. It is difficult to overestimate the value—or the difficulty—of coordinating services. Parents who do not have access to case management services may want to arrange a meeting with people from the school, each outside agency, and even a parent support or advocacy organization, so that communication is clear and efforts coordinated. An advocate or another parent can provide support and encouragement for parents who are confused, intimidated, or overwhelmed by the often overlapping responsibilities of various agencies.

The role of parents in supporting their child at home complements their role as advocates for appropriate services. When a child's home life is unstable or when families are too exhausted, too angry, or overwhelmed by competing responsibilities for other family members, a more restrictive level of services is more likely to be required. In other words, if families do not receive the support they need in caring for a child, it increases the risk that out-of-home placement will become the only alternative for their child. Yet the "simple" things—respite care for weary parents, information on how to challenge agency policies appropriately, or specific behavior management techniques—often mean the difference between a child being able to remain at home and being placed in a residential setting.

Advocacy is necessary to ensure that children with emotional and behavioral disorders have the same opportunity as other children to remain with their families and that when out-of-home placement or residential treatment is necessary, those services are available in the child's community.

Parents as Advocates

Some parents have the time, energy, and commitment to participate in organized advocacy activities, while others have all they can do to help their child make it from one day to the next. Some parents may enjoy the challenge of participating on weekly or monthly committees, while others would rather work behind the scenes. Regardless of expertise, energy, or time, nearly every parent can find a way to lend support to necessary advocacy for mental health services for children and youth.

Join a support group or self-help group to find support and affirmation and to learn about existing resources for your family. If you cannot find a local group, think about starting one; the majority of existing support and self-help groups are organized and run by parents of children with emotional or behavioral disorders. Call PACER or any of the parent groups in the appendices of this book for information. Good quality written materials offer ideas for starting and facilitating support groups for parents of children with emotional or behavioral disorders, as well as tips on topics and speakers to keep the group lively and informed.

Call your State Mental Health Representative for Children and Youth (SMHRCY). Ask the SMHRCY representative what parents can do to help. Possibilities include public speaking, reviewing your state mental health plan, making telephone calls, organizing a workshop, or serving on a children's mental health committee. One of the major contributions parents can make to the status of children's mental health services in their state is to read and comment on their state plan for developing services. The state's Department of Mental Health can assist families in locating their SMHRCY representative.

Call your state's Department of Education to find out whether your state has an initiative going to improve services to children with emotional or behavioral disorders. For instance, in Minnesota, the Department of Children, Families & Learning has organized an EBD/Mental Health Advisory Group of teachers, parents, advocates, and mental health representatives to find ways in which schools can better serve the needs of children with emotional and behavioral disorders. Many subgroups of the committee meet to address specific issues related to teacher training, curriculum, collaboration, etc.

Call your state universities to find out whether they have a training or licensure program for special education teachers who instruct children with emotional or behavioral disorders. Ask what the curriculum covers. Parents should let the university know if they believe there are additional training needs. Many universities and colleges have asked parents to address classes about the difficulties of raising a child with emotional or behavioral disorders, and to make recommendations to new teachers, psychologists, social workers, or administrators about how to improve communication or services. Remember that the unique perspective of parents is valuable; parents should not be shy about asking for a speaker's fee, just as any other expert might. Parents may volunteer their time if they choose, but should not be required to do so if other speakers are reimbursed.

Call your state's Department of Corrections and ask what kinds of educational programs exist in your state for juveniles in correctional settings. Students who receive special education services in schools are also entitled to those services in correctional and other settings. Some parents may want to volunteer to serve as a "surrogate parent" for children in need by participating in the development of an individualized education program for a child who does not have parents. Others may offer to locate information about children with disabilities to share with juvenile probation officers, guardians ad litem, judges, public defenders, or other interested people. Libraries are good resources for current information, as is your state's Parent Training and Information Center.

Apply for membership in state or local policy committees concerned with developing services for children with emotional or behavioral disorders. The state SMHRCY representative should be able to help families identify key committees. If the committee memberships are full, parents may still sit in on any public meeting to learn what is happening in their community or state.

Visit your state legislators and your congressional representatives. Know their positions on community-based mental health services for children. Family members may call the Federation of Families for Children's Mental Health or the National Alliance for the Mentally Ill for current information about children's needs and initiatives at the federal and state level, and offer to share it with their elected officials. Parents should follow up any visit with a note of appreciation to the legislator for taking the time to learn about the mental health needs of children, then call whenever relevant legislation is proposed to let the representative know where they stand.

Do nothing at all. Just sit there when you can, and remember that there are people in the world—many thousands of them—who share your family's hopes and dreams for children, and who share your concerns and dismay as well. Doing nothing is enormously undervalued. Doing nothing can give parents a few minutes of rest before the next "event" and provide the energy to continue. It may allow parents to clear their heads, take a brief nap, memorize a poem, walk in the park, or reflect on the fact that, in spite of what lies ahead, parents and families are their child's best hope for the future.

Practical Strategies for Home

In addition to the need for services, there are some simple and practical things parents and family members can learn to do to help with everyday problems and to reduce conflict between family members.

Be the best parent you can be. Parents may want to enhance their behavior management skills at a seminar, through books or videotapes at the library, or by signing up for a "parenting" class. Despite the misleading title, many parenting classes actually focus on behavior management and communication skills. Parents should never be embarrassed by a need to learn new skills. Many specialized educational opportunities must be sought by families of children with emotional or behavioral disorders because "typical" child-rearing skills are often not enough.

Listen to your child. Communication between children and adults in the caretaking role is an important part of maintaining family stability. When parents take an active interest in their children's thoughts and feelings and share their own feelings openly, children learn that talking about how they feel is a normal part of growing up. Open expressions of feeling are an important part of maintaining mental health. Modeling honest communication is a powerful teaching tool.

Teach your child to problem-solve. By teaching a child the specific steps of a problem-solving technique (if the child's emotional condition is such that he or she is able to learn), and then using the technique when disagreements arise, many conflicts can be dealt with before they become severe. This is an example of a typical problem-solving approach:

1. *What is the problem? What caused the conflict?* Conflicts between children are often are related to territorial disputes ("That's my chair . . . I was sitting there first!") or name-calling. Conflicts between child and parent are more often issues of noncompliance ("I told you to stay in your room until your homework is finished!") Sometimes, children with emotional and behavioral disorders do not have the training to understand their role in creating a conflict, and will need a parents' help in identifying the problem.
2. *What does each person want?*

3. *What are some possible solutions to the problem?* Write down as many solutions as all parties can think of on how to resolve the problem. Through a process of give and take, settle on one solution that all agree to try.
4. *Did the solution work?* Should another possible solution be tried?

Praise and encourage your child. Encouragement promotes self-confidence. When children first learn how to walk, it is not because they are spanked for falling, but because parents hold them up, encourage them to stand, and praise them for showing any approximation of the skills required for walking. When they fall, as all children will, parents are on the scene to pick them up again, reassure them and repeat the process of encouragement and praise until, finally, children walk on their own. Raising successful children has much to do with how they are nurtured, especially those children that are the most difficult to manage. Children depend on the adults in their lives to tell them that they are valued and that it is okay to make mistakes. When positive behavior is reinforced by others, it will be repeated and become part of a child's repertoire of behaviors. Behaviors—good or bad—that are not reinforced tend to disappear. If children learn that mistakes (or missteps) are simply valuable learning experiences, not a sign of failure, they will be more willing to take chances.

Create win-win situations when possible. When children do not comply with adult requests, there are only three things parents can do: withdraw the request (parents lose), use punishment for noncompliance (child loses), or offer a reward for compliance (both parent and child get what they want).

Research shows that punishment is less effective than a reward for completing a task on time. The request-reward approach is especially effective with adolescents: "If you clean your room this weekend, you can have a group of friends over for pizza." It gives power to both parents and children. This creates a win-win situation, rather than the win-lose that characterizes so many adult-child interactions.

When punishment is used to gain compliance, the follow-through with consequences is more important than the severity of the consequence. When parents do not follow through with agreed-upon, reasonable consequences, a child quickly learns that he or she may get away with unacceptable behavior.

Spanking, yelling, or other methods of coercing children to do as adults request can teach them to react violently or angrily when their own needs are not being met. Parents who use spanking to discipline children risk that children are learning that physical force is the way to get what you need when others resist. Because children behave as their models do, this particular model may demonstrate that physical force is the way to respond to someone who refuses to comply with a request. When adults speak politely and follow through with rewards and consequences, children learn to become reasonable in their own demands as they get older.

The home environment has a powerful influence on how children develop and grow. While abuse teaches abuse, so too does positive, loving discipline teach positive, loving discipline. Even the most positive home, however, cannot prevent the development of serious emotional and behavioral disorders for some children. When problems arise in spite of their best parenting techniques, it is especially important that families seek help for their child.

Recognize the common phases families go through. When a child's emotional state or behavior is becoming a problem, families may find themselves undergoing change in response to the child's needs. Often families find themselves more isolated from extended family members, friends, the school, or the community. Power struggles among siblings may become more intense, and couples may face increased tension. Taking time to look for signs of family distress before there is a crisis is the best way to address the problem before it overwhelms the family. Family counseling or therapy, for instance, may be effective in alleviating some of the stresses before they escalate into major crises or family separation.

Remember that even in chaos there is predictability. Parents already know how their child will respond to a specific voice tone or directive and what should or should not be said to help the child maintain control. It is important for parents to understand their own emotional "buttons"—the things a child might say or do that leads them to become angry—so they can plan how to respond in a manner that will not escalate an argument or crisis at home. Knowing as much as they do about their child's behavior (and their own) can help parents become the true expert in home crisis intervention.

Plan ahead for a crisis. When families have a crisis plan to ensure that communication between adults and children remains possible, they may be able to de-escalate a child's anger or anxiety. If families have already faced an emergency situation because of their child's behavior, they have some ideas about what helped and what did not. Change and crisis cause stress for the entire family. Families may want to plan ahead for the next potential emergency by talking about ways family members can support one another during times of crisis. A written plan of action can be helpful; it is amazing how much parents and siblings, when faced with an emergency, can do when they have a plan.

Many families seek a support system outside the family (friends, a support group, a counselor, a church or community organization) to help the family solve problems and maintain perspective. Here are some questions parents may want to consider when their child's behavior is becoming a problem:

1. Does your child's behavior escalate if you become visibly angry? If so, parents may need to learn to moderate their voices and behavior in order to help the child maintain or regain control. Sometimes a soft tone of voice in response to inappropriate behavior provides the reassurance that a youngster needs to try to remain calm. While this skill often requires practice to become comfortable, it works in setting the tone for resolving problems and teaches the child a more acceptable way to express anger or frustration.
2. Does touching calm or excite your child? Some children respond very negatively to being touched while they are angry and may strike out at the person touching them. Other children find that a gentle hand on the shoulder, especially when combined with a soft voice, has a soothing effect. Understanding a child's individual response can help in developing a plan to help the child manage his or her own behaviors.
3. Would walking away help or harm the situation? Some children become even angrier when a parent walks away during an argument, and they take their frustrations out on smaller family members or property. Others use the time to calm down and to regain control. Knowing what works with a child allows parents to be prepared for future problems.

Forgive yourself. Parents of children with emotional or behavioral disorders are as entitled to bad moods, frustration, anger, and the breadth of other human emotions as any other person, even when those feelings are at times directed toward their children. What would happen to children if parents were perfect? For one thing, they would not have a chance to learn to deal with the variable moods that everyone has from time to time and would never see how adults deal with making mistakes. Anger or a bad mood is not harmful to children when parents are able to talk about their feelings and not demean children with verbal attacks or physical abuse. When parents apologize to their children for their own human errors, and learn from them, they are modeling behaviors that help children learn how to become caring, responsible adults.

Don't feel guilty if you need a break! Every parent feels exhausted, helpless, or overwhelmed at times. Sometimes parents need a break, not just from their child, but from the responsibility for taking the lead in locating and coordinating services or advocating for services. The fragmentation of the mental health system existed long before parents became involved and may continue for some time into the future.

While arranging appropriate services for your child is extremely important, so is maintaining your own health and stability. Many parents miss the opportunity to receive help they truly need because they are reluctant to ask for help until their situation becomes desperate. Yet, asking for help is a prerequisite to receiving help. Parents may want to seek out a family member, another parent, or a provider or advocate who can help in times of stress. If you need a break, you should not feel guilty about taking one!

Looking to the Future

Among the greatest accomplishments in children's mental health have been the shift toward local services, which permits families to remain together, and the inclusion of families in the design and delivery of services. The past decade has also seen advances in understanding emotional disorders and mental illnesses in children and adolescents. Advanced research and new technologies have led to greater understanding of the relationships between the brain and behavior. After decades of blaming parents for their children's mental health problems, many researchers and providers are beginning to understand that the origins of emotional and behavioral disorders are far too complex to be explained by "inadequate parenting."

This book has focused on the growing recognition that most children experiencing mental health problems can be served within their homes and their communities. Local wraparound or multiagency services are based on the assumption that children do best when they receive services in as normalized a setting as possible, remaining in their family home, or with another family in their own community. Families have strengths even when they need the support of their communities to raise healthy children. Services must be built on respect for the family and for the family's preferences.

Many states and communities are looking at community-based services as an alternative to residential services. One of the attractions of such services for providers is the expectation that community services will be cheaper to provide than residential treatment. Evidence does show that an array of services provided to a child in his or her community is less expensive, in the long run, than placing the child in a treatment or residential facility. However, the reason for providing community-based services to children and their families should be that the children are more appropriately served, not simply that there may be cost savings associated with nonresidential services.

When a community decides to deliver mental health services to children and their families locally, providers must be diligent about offering services that are of sufficient scope, duration, and intensity to meet the family's needs. Services that focus only on in-home interventions, or only on outpatient counseling, without offering other services such as respite care, after-school and recreational programs, medicine management, school programming, crisis services, or transition planning, may not address the continuum of needs that families experience in caring for their child.

The danger is that poorly designed or inadequately staffed community-based services that do not result in improved functioning for children and their families will be used to illustrate the "failure" of community-based interventions and lead to the rejection of this model of care.

The move away from seeing families as part of the problem to seeing them as integral members of the treatment team for their child has led to greater parent advocacy at all levels on behalf of children with emotional disorders. The acceptance of families as co-experts is not universal, however, and much remains to be done. Great strides can be made when parents organize and recognize that their children's needs are shared with many others. Parents of children with emotional and behavioral disorders, like parents of children with other disabilities, may find that one of their many roles in finding help for their child requires that they develop specific skills in learning how to negotiate systems. While this is very difficult for parents to do on their own, it is more easily achieved when pursued by a group.

Today, in nearly every state, parents who need support can find organized groups or other parents who offer information, support, and referral to resources. Many parents and caring providers are already advocating for children with emotional or behavioral disorders. When they join together, the gaps in services can be better addressed than when one parent struggles alone to find answers.

Parents who believe their child can be better served at home or in another family-like setting in their community must be assertive about requesting less restrictive services. They must also advocate for services of sufficient quantity and quality to ensure their child has an opportunity to succeed.

People interested in joining or organizing advocacy efforts to improve services in their own communities or state may call any of the parent organizations listed in the Appendices of this book. Or they may call the EBD Project at PACER Center for referral to groups or individuals in their area.

Organizations Concerned with Children's Mental Health

American Academy of Child and Adolescent Psychiatry
3615 Wisconsin Ave. NW
Washington, DC 20016
(202) 966-7300
www.aacap.org

American Anorexia and Bulimia Association
165 W. 46th St., Ste. 1108
New York, NY 10036
(212) 575-6200
www.aabainc.org

Anxiety Disorders Association of America
11900 Parklawn Drive, Ste. 100
Rockville, MD 20852
(301) 231-9350
www.adaa.org

Bazelon Center for Mental Health Law
1101 15th St. NW, Ste. 1212
Washington, DC 20005-5002
(202) 467-5730, 467-4232
www.bazelon.org

Children's Defense Fund
25 E. St. NW
Washington, DC 20001
(202) 628-8787
www.childrensdefense.org

Children with Attention Deficit Disorder
8181 Professional Place, Ste. 201
Landover, MD 20785
(800) 233-4050
www.chadd.org

Council for Children With Behavior Disorders—CCBD
Eric Resource Library
1110 N. Glebe Rd., Ste. 300
Arlington, VA 22201
(800) 328-0272
www.cec.sped.org

Families and Advocates Partnership for Education—FAPE
8161 Normandale Blvd.
Minneapolis, MN 55437-1044
(952) 838-9000
(952) 838-0190 TTY
(952) 838-0199 fax
(888) 248-0822 toll-free
www.fape.org

Federation of Families For Children's Mental Health
1101 King Street
Alexandria, VA 22314
(703) 684-7710
www.ffcmh.org

Learning Disabilities Association
4156 Library Road
Pittsburgh, PA 15234-1349
(412) 341-1515
www.ldaamerica.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Blvd., Ste. 300
Arlington, VA 22201-3042
(800) 950-NAMI (6264)
www.nami.org

National Depressive and Manic-Depressive Association
730 N. Franklin St., Ste. 501
Chicago, IL 60610-3526
(800) 82-NDMDA
www.ndmda.org

National Information Center For Children and Youth with Disabilities
P.O. Box 1492
Washington, DC 20013
1-800-695-0285
(202) 884-8200
www.nichcy.org

National Mental Health Association
1021 Prince St.
Alexandria, VA 22314-2971
(703) 684-7722
www.nmha.org

National Parent Network on Disabilities
1130 17th St. N.W., Ste. 400
Washington, DC 20036-4641
(202) 463-2299
www.npnd.org

Obsessive-Compulsive Foundation
337 Notch Hill Rd.
North Branford, CT 06471
(203) 315-2190
www.ocfoundation.org

PACER Center, Inc.
8161 Normandale Blvd.
Minneapolis, MN 55437-1044
(952) 838-9000 voice
(952) 838-0190 TTY
(952) 838-0199 fax
(800) 53-PACER toll-free in Minnesota
www.pacer.org

R & T Center on Family Support and Children's Mental Health
Regional Research Institute
Portland State University
P.O. Box 751
Portland, OR 97207-0751
(503) 725-4040
www.rtc.pdx.edu

Organizations for Parents of Children with Emotional or Behavioral Disorders

This is a list of some parent organizations serving families of children with emotional or behavioral disorders. There are many other groups and individuals who have organized to serve families that may not be listed here. Parents may call the Federation of Families for Children's Mental Health if they need a resource for their own area or state that is not listed here. The number is (703) 684-7710.

ALABAMA

Helping Other Parents Explore
H.O.P.E. Alternatives
940 Montclair Road, Suite 200
Birmingham, AL 35213
(205) 595-4555

ALASKA

Alaska Attachment & Bonding Association
3300 Palmdale
Wasilla, AK 99654
(907) 376-0366
(907) 376-3840 fax
bj@pobox.alaska.net

Alaska FFCMH
4045 Lake Otis Pkwy.
Suite 209
Anchorage, AK 99508
(907) 563-0880
(907) 563-0881 fax
(800) 478-0880
mhaa@alaska.net

ARKANSAS

Arkansas FFCMH
4313 West Markham
Little Rock, AR 72205
(501) 686-9060
(501) 686-9549 fax

ARIZONA

Mentally Ill Kids in Distress
755 East Willetta, Ste. 128
Phoenix, AZ 85006
(602) 253-1240
(602) 253-1250 fax
In-State (800) 35-MIKID
MIKIDAZ@worldnet.att.net

CALIFORNIA

Bridging the Gap
3123 West Lemondwood Drive
Lancaster, CA 93536

Heartbeat Families United
Project Heartbeat
1357 Seventh Ave., Ste. C
San Diego, CA 92101
(619) 615-7671 x22
(619) 615-6284 fax
chnter@aol.com

Matrix Parent Network
2261 Elm St.
Napa, CA 94559
(707) 259-8174
(707) 259-8651 fax
jklmatrix@aol.com

Parents Helping Parents
594 Monterey Blvd.
San Francisco, CA 94127
(415) 841-8820
(415) 841-8824 fax

United Advocates for Children of California
P.O. Box 8900
Emeryville, CA 94662-8900
(510) 547-8754
uacc@pacbell.net

COLORADO

Colorado FFCMH
P.O. Box 200188
Denver, CO 80220
(303) 572-0302
(303) 572-0304 fax
(888) 569-7500

Northern Colorado FFCMH
1400 White Peak Court
Fort Collins, CO 80525
Home: (970) 223-3036
(970) 377-0245 fax
74264.2641@compuserve.com

CONNECTICUT

MHA of Connecticut Family
Advocate Program
2030 Beaver Road
Weathersfield, CT 06109
(203) 272-4542
(860) 529-6833 fax
In-State: (800) 842-1501

DELAWARE

Mental Health Association of Delaware
1813 N. Franklin St.
Wilmington, DE 19802
(302) 656-8308
(302) 656-0747 fax

DISTRICT OF COLUMBIA

Family Advocacy & Support Association
P.O. Box 73367
Washington, DC 20056-4884
(202) 576-7154
(202) 576-8804 fax

FLORIDA

Big Ben FFCMH
3927 Spring Creek Hwy.
Crawfordville, FL 32327
(850) 487-1542
(850) 926-2523 fax

FFCMH of Hillsborough County
1205 E. 8th Ave.
Tampa, FL 33605
(813) 229-2884
(813) 228-8122 fax

GEORGIA

GA Parent Support Network
1381 Metropolitan Pkwy.
Atlanta, GA 30310
Home: (404) 753-3858
(404) 785-4500
(404) 785-6833 fax

HAWAII

Hawaii Families as Allies
P.O. Box 700310
Kapolei, HI 96709-0310
(808) 674-0732 x114
(808) 674-0780 fax
HFAllies@aol.com

IDAHO

IDAHO FFCMH
1111 South Orchard, Ste. 250
Boise, ID 83705
(208) 334-5525
(208) 334-6664 fax

ILLINOIS

Illinois Federation of Families (IFF)
800 W Roosevelt, Bldg. 5D 107
Glen Ellen, IL 60137
Home: (847) 973-8976
(800) 871-8400
(630) 545-5022 fax
kgfamilies@aol.com

CANDU Parent Group
24W 681 Woodcrest Drive
Naperville, IL 60540

F.A.N.S
2512 South Wood Drive
Champaign, IL 61821
(217) 356-0113
(217) 355-3166 fax

Parent Information Network / APO
P.O. Box 1088
Lake Villa, IL 60046
(847) 356-2393 fax

Parents Supporting Parents
910-½ South Adelaide
Normal, IL 61761

INDIANA

Families Reaching for Rainbows
FFCMH MHA in Marion County
2506 Willowbrook Parkway, Ste. 100
Indianapolis, IN 46205
(317) 251-0005
(317) 254-2800 fax

Indiana FFCMH
55 Monument Circle, Ste. #455
Indianapolis, IN 46204
(317) 638-3501
(317) 638-3540 fax
In State (800) 555-6424

IOWA

Iowa FFCMH
303 West Main
P.O. Box 362
Anamosa, IA 52205
(319) 462-2187
(319) 462-6789 fax
iaffcmhdir@aol.com

KANSAS

Keys for Networking, Inc.
Kansas FFCMH
117 SW 6th Ave.
Topeka, KS 66603
(785) 233-8732
(785) 235-6659 fax
In-State (800) 499-8732

Heartland Parent Support Network
1616 Lake Ave.
Kansas City, KS 66103
(636) 394-9563

Parent T.E.A.M.S., Inc.
P.O. Box 258 / 1730 Belmont
Parsons, KS 67357
(316) 421-3736
(316) 421-4583 fax

KENTUCKY

Kentucky Partnership
for Families and Children
1410 Versailles Road #6
Frankfort, KY 40601
(502) 695-5366
(502) 695-3410
(502) 695-6829 fax
In-State (800) 369-0533

KY SPIN / VRI
Louisville, KY 40218
(502) 456-0923
(502) 456-0893 fax
(800) 525-7746
spininc@aol.com

LOUISIANA

Louisiana FFCMH
P.O. Box 4767
Shreveport, LA 71134-0767
(318) 227-2796
(318) 227-2793 fax
lafofcmh@aol.com

MAINE

Western ME Parent Awareness
922 Gore Road
Otisfield, ME 04270
(207) 743-6368

MARYLAND

Families Involved Together
5000 York Road, 3rd Floor
Baltimore, MD 21212
(410) 464-2606
(410) 464-2607 fax
In-State (800) 498-5551

Montgomery County Chapter of FFCMH
17717 Cliffbourne Lane
Derwood, MD 20855
(301) 217-1289

MASSACHUSETTS

Parent Professional Advocacy League
14 Beacon St. #706
Boston, MA 02108
(617) 227-2925
(617) 227-1755 fax
In-State (800) 537-0446

MICHIGAN

Association for Children's Mental Health
941 Abbott Road
East Lansing, MI 48823
(517) 336-7222
(517) 336-8884 fax
acmhinc@aol.com

Michigan Association for Children with Emotional Disorders
321 West South St.
Kalamazoo, MI 49007
(616) 343-5896
(616) 344-4645 fax
Michigan Association for Children with Emotional Disorders
15920 West Twelve Mile Road #201
Southfield, MI 48076
(248) 552-0044
(248) 552-0047 fax

MINNESOTA

Minnesota Association for Children's Mental Health
1821 University Ave. W., Ste. N-184
St. Paul, MN 55104
(651) 644-7333
(651) 644-7391 fax
In-State (800) 528-4511
dsaxhaug@macmh.org

PACER Center, Inc.
8161 Normandale Blvd.
Minneapolis, MN 55437-1044
(952) 838-9000 voice
(952) 838-0190 TTY
(952) 838-0199 fax
(800) 53-PACER toll-free in Minnesota
www.pacer.org

MISSISSIPPI

Mississippi Families as Allies
5166 Keele St. B-100
Jackson, MS 39206
(601) 981-1618
(601) 981-1696 fax
In-State (800) 833-9671
msfaa@netdoor.com

Gulf Coast Chapter FFCMH
220 Bay Oaks Drive
Bay St. Louis, MS 39520

South Central Support Group
P.O. Box 122
Petal, MS 39465

MISSOURI

MO-SPAN
440 A Rue St. Francois
Florissant, MO 63031
(314) 972-0600
(314) 972-0606 fax

MO-SPAN Central Region
2623 Idlewood Road
Jefferson City, MO 65109

MO-SPAN NW Region
2501 Woodrail Ave.
Richmond, MO 64085

MO-SPAN SE Region
505 Nevada Drive
Bismarck, MO 63624
(573) 734-2153

MO-SPAN SW Region
210 West Vine
Butler, MO 64730

MONTANA

Family Support Network
P.O. Box 21366
Billings, MT 59104
(406) 256-7783
(406) 256-9879 fax

NEBRASKA

Nebraska Family Support Network
215 Centennial Mall South 220
Lincoln, NE 68508-1813
(402) 477-2992
(402) 477-3192 fax
In-State (800) 245-6081

NEVADA

Nevada PEP, Inc.
2810 West Charleston, Ste. G-68
Las Vegas, NV 89102
(702) 388-8899
(702) 388-2966 fax
nvpep@vegas.infi.net

NEW HAMPSHIRE

Alliance for the Mentally Ill of New Hampshire
10 Ferry St. 314
Concord, NH 03301
(603) 225-5359
(603) 228-8848 fax
In-State (800) 242-6264
naminh@conknet.com

Granite State FFCMH
679 Mast Road
Manchester, NH 03102
(603) 626-0900

NEW JERSEY

Families Finding Hope
8 Tudor Court
Medford, NJ 08055
(609) 714-1353

NJ Parents Caucus
265 Oak Ridge Ave.
Summit, NJ 07901
(908) 522-1120
(908) 522-1888 fax

Statewide Parent Advocacy Network
35 Halsey St.
Newark, NJ 07102
(973) 642-8100 x105
(973) 642-8080 fax
span@bellatlantic.net

NEW MEXICO

Parents for Behaviorally Different Children
5905 Marble NE, Ste. 8
Albuquerque, NM 87110
(505) 265-0430
(505) 255-6578 fax

NEW YORK

Families Together of New York State
415 River St.
Troy, NY 12180
(518) 274-4042
(518) 274-1320 fax
In-State (888) FAM-TOGH
famtogh@albany.net

Families United Network,
c/o Parsons Child and Family Center
60 Academy Road
Albany, NY 12208
(518) 426-2600
(518) 447-5234 fax

Finger Lakes Parent Network, Inc.
Patti DiNardo
25 West Steuben Street
Bath, NY 14810-1511
Home: (716) 289-4874
(607) 776-2164
(716) 289-3501 fax
edinardo@eznet.net

Mental Health Association in Duchess County
510 Haight Ave.
Poughkeepsie, NY 12603
(914) 473-2500
(914) 473-4870 fax

Monroe County FFCMH /Better Days Ahead
339 East Ave., Ste. 201
Rochester, NY 14604-2615
(716) 325-3145 x16
(716) 325-3188 fax

Parent Support Network MHA
of Rockland County, Inc.
20 Squadron Blvd.
New City, NY 10956
(914) 639-7400 x26
(914) 359-6248 fax

WITS End Family Support / Vanderhyden Hall, Inc.
P.O. Box 219
Wynantskill, NY 12198
(518) 283-3458 x15
(518) 283-3347 fax

NORTH CAROLINA

WE CARE FFCMH
319 C St. Andrews Drive
Greenville, NC 27834
(252) 439-0038
(252) 439-0043 fax
wecare@greenvillenc.com

WNC Families CAN
P.O. Box 665
Arden, NC 28704
(828) 687-1157
Fax: (828) 687-1163 fax
wncfamilies@earthlink.net

NORTH DAKOTA

ND FFCMH
P.O. Box 3061
Bismarck, ND 58502-3061
(701) 250-1795
ndkfed@btigate.com

ND FFCMH Region V
1104 2nd Ave., South
Fargo, ND 58103
(701) 235-6948
(701) 235-9923 fax
ndffrg19@idet.net

ND FFCMH Region VII
P.O. Box 3061
Bismarck, ND 58502-3061
(701) 222-1223
Fax: (701) 250-8835 fax

OHIO

Concerned Advocates Serving Children & Families
2555 Lyndale, NW
Missillon, OH 44646
(330) 454-1476 fax

Dream Catchers Family Advocates
P.O. Box 1263
Portsmouth, OH 45662
(740) 353-4946
(740) 353-6512 fax

FFCMH of Central Ohio
1438 East 19th St.
Columbus, OH 43211

First Ohio Chapter—FFCMH
4505 Quaker Court
Canfiled, OH 44406
(330) 726-9570
(330) 726-9031 fax

First Step
1724 Herbert Circle
Canal Fulton, OH 44614
(330) 854-5774
Fax (440) 439-1966 fax

OH Family Organization for Children's
Mental Health, Inc.
11647 Hamlet Road
Cincinnati, OH 45240-1907
(513) 851-9884

Positive Education Program
3100 Euclid Ave.
Cleveland, OH 44115
(216) 361-4400
(216) 361-8600 fax

OKLAHOMA

OK AMI
5131 North Classen Blvd., Ste. 110
Oklahoma City, OK 73118
(405) 840-4746
(405) 848-1220 fax
In-State (800) 645-5437

OREGON

Oregon Family Support Network
P.O. Box 13820
Salem, OR 97309-1820
(503) 581-2047
(503) 581-4841 fax
ofsn@open.org

PENNSYLVANIA

Parents Involved Network of Pennsylvania
1211 Chestnut Street 11th Floor
Philadelphia, PA 19107
(215) 751-1800 x214
(215) 636-6300 fax
In-State (800) 688-4226 x214
www.pinofpa.org

PUERTO RICO

Asoc. De Padres pro Bienestar de Niños con Impedimentos
P.O. Box 21301
Rio Piedras, PR 00928
(787) 763-4665
(787) 765-0345 fax

RHODE ISLAND

Parent Support Network
400 Warwick Ave. #12
Warwick, RI 02888
(401) 467-6855
(401) 467-6903 fax
In-State (800) 483-8844

Parent Support Network
4 Shore Road
Westerly, RI 02891

SOUTH CAROLINA

Family Support Network /SC AMI
P.O. Box 21586
Columbia, SC 29221-1586
(803) 561-0000
(803) 561-9840 fax
In-State (800) 788-5131

Federation of Families of SC, MHASC
1823 Gadsden St.
Columbia, SC 29201
(803) 779-5363
(803) 779-0017 fax
In-State (800) 375-9894
mhasc@colum.mindspring.com

The Village Program
1 Carriage Lane G
Charleston, SC 29407
(843) 852-4125
(843) 852-4130 fax

SOUTH DAKOTA

Parent Support Network
2609 South Elmwood Ave.
Sioux Falls, SD 57105

TENNESSEE

Tennessee Voices for Children, Inc.
1315 8th Ave., South
Nashville, TN 37203
(615) 269-7751
(615) 269-8914 fax
In-State (800) 670-9882
tvc@tnvoices.org

TEXAS

Bell County Chapter FFCMH
10707 Pendleton Troy Road
Troy, TX 76579
(254) 938-2307
(254) 938-2431 fax

Central Texas FFCMH
6418 Orange Blossom
Austin, Texas 78744
(512) 282-5817 fax

Dallas FFCMH
MHA of Greater Dallas
624 North Good-Latimer #200
Dallas, TX 75204
(214) 871-2420
(214) 954-0611 fax
Srogers@mhadallas.org

FFCMH of Austin, Travis County
6602 Lancret Hill Drive
Austin, TX 78745
(512) 445-7701 fax

Grayson County FFCMH
4820-C Highgrove
Sherman, TX 75090
(903) 883-3742 fax
patoadv@texoma.net

Gulf Coast FFCMH
Drawer O
Santa Fe, TX 77510
(800) 839-8876
(409) 756-8326 fax
ParentCnt@aol.com

Harris County FFCMH
4103 Wild Acres Drive
Houston, TX 77072
(713) 970-4417
(281) 530-3938 fax

Southeast Houston
6515 Hillcroft St., Apt. 441
Houston, TX 77081
(713) 777-0195

Texas FFCMH
7701 North Lamar #500
Austin, Texas 78752
(512) 451-3191
(512) 451-8302 fax
In-State (800) 860-6057
Patti_Derr@tmhc.org

UTAH

Allies with Families
535 East 4500, South
Salt Lake City, UT 84107
(801) 269-8553
(801) 269-8302 fax

VERMONT

Vermont FFCMH
P.O. Box 607
Montpelier, VT 05601-0607
(802) 223-4917
(802) 828-2159 fax
vffcmh@together.net

VIRGINIA

Children Have a Right to Succeed
(CHARTS) – FFCMH
3504 Vaughan Creek Drive
Hayes, VA 23072
(804) 642-2085
(804) 693-7407 fax

Families First of Alexandria, Inc.
817 Little St.
Alexandria, VA 22301
(703) 548-0539 fax
FAM1stalex@aol.com

PACCT
7286 Ewell Circle
Mechanicsville, VA 23111
(804) 559-6833
(804) 559-6835 fax

Parent Resource Network
909 Chimborazo Blvd.
Richmond, VA 23223
(804) 222-0455
(804) 222-0581 fax

WASHINGTON

Federation of Families
2832 Sunset Lane, NE
Renton, WA 98056
(425) 277-0426
(425) 277-5010 fax
marilynn@rocketmail.com

Everett Village Moms FFCMH
Pacific Crest Family Support
2731 Wetmore Ave., Ste. #220
Everett, WA 98201-3581
(425) 252-7716

Inland NW Chapter Federation of Families
8024 E. Lewis Lane
Spokane, WA 99212
(509) 893-9831

Parents for Parents: Moving Beyond Blame
11320 238th SW
Edmonds, WA 98020
(206) 542-5491
ppmbb@aol.com

Renton Children's Inalienable Rights
to Services Chapter of Federation of Families
16405 S.E. Maple Valley Hwy. #20
Renton, WA 98058
(425) 235-7316

Seattle Parent Advocacy Network
2142 10th Ave., W
Seattle, WA 98119
(206) 298-9626
(206) 284-7843 fax
rbelz@seattlechildrenshome.org

Tacoma Chapter of FOF
5918 26th St., NE
Tacoma, WA 98422
(253) 927-1620

Thurston County FFCMH
3625 Arbor Drive, SE
Lacey, WA 98503
(360) 413-7804

A Village Project FFCMH
323 W. Cloudy St.
Kent, WA 98032
(253) 850-7681
(253) 520-7661 fax

WEST VIRGINIA

Mountain State Parent Children
& Adolescent Network
P.O. Box 6658
Wheeling, WV 26003-0906
(304) 233-5399
(304) 233-3847 fax
In-State (800) 244-5385
mspcandir@aol.com

Barbour County You Are Not Alone Support Group
Rt. 1, Box 218 E
Philippi, WV 26416
(304) 457-2691
(304) 457-2693 fax
BCFRN@access.mountain.net

United Summit Parent Center
6 Hospital Plaza
Clarksburg, WV 26301
(800) 786-6486
(304) 623-2989 fax

WISCONSIN

Wisconsin Family Ties
16 North Carroll St. #640
Madison, WI 53703
(608) 267-6888
(608) 267-6801 fax
In-State (800) 422-7145

Families United of Milwaukee
9501 Waterton Plank Road
Milwaukee, WI 53226
(414) 257-6857
(414) 257-7575 fax

W.A.T.C.H
First Love Community Outreach Center
429 W.N. Ave.
Milwaukee, WI 23212
(414) 263-3375
(414) 263-1148 fax

WYOMING

UPLIFT
P.O. Box 664
Cheyenne, WY 82003-0664
(307) 778-8686
(307) 778-8681 fax
uplift@wyoming.com

Parent Training and Information Centers

The national coordinating office for the Technical Assistance Alliance for Parent Centers is at PACER Center. For more information about the 100 Parent Training and Information Centers and Community Parent Resource Centers, call toll-free 1-888-248-0822, or visit the Alliance Web site at *www.taalliance.com.*

ALABAMA

Special Education Action Committee Inc.
P.O. Box 161274
Mobile, AL 36616-2274
334-478-1208 voice & TDD
334-473-7877 fax
1-800-222-7322 AL only
seacofmobile@zebra.net
home.hiwaay.net/~seachsv

ALASKA

PARENTS, Inc.
4743 E. Northern Lights Blvd.
Anchorage, AK 99508
907-337-7678 voice
907-337-7629 TDD
907-337-7671 fax
1-800-478-7678 in AK
parents@parentsinc.org
www.parentsinc.org

AMERICAN SAMOA

American Samoa PAVE
P.O. Box 6844
Pago Pago, AS 96799
011-684-699-6946
011-684-699-6952 fax
SAMPAVE@samoatelco.com
www.taalliance.org/ptis/amsamoa

ARIZONA

Pilot Parents of Southern Arizona
2600 North Wyatt Drive
Tucson, AZ 85712
520-324-3150
520-324-3152
ppsa@pilotparents.org
www.pilotparents.org
Southern AZ

RAISING Special Kids
4750 N. Black Canyon Hwy, Ste. 101
Phoenix, AZ 85017-3621
602-242-4366 voice & TDD
602-242-4306 fax
1-800-237-3007 in AZ
Central and Northern AZ
raisingspecialk1@qwest.net

ARKANSAS

Arkansas Disability Coalition
1123 University Ave., Ste. 225
Little Rock, AR 72204-1605
501-614-7020 voice & TDD
501-614-9082 fax
1-800-223-1330 AR only
adc@alltel.net
www.adcpti.org
Statewide with FOCUS AR

FOCUS, Inc.
305 West Jefferson Ave.
Jonesboro, AR 72401
870-935-2750 voice
870-931-3755 fax
888-247-3755
focusinc@ipa.net
www.grnco.net/~norre
With Arkansas Disability Coalition AR

CALIFORNIA

DREDF
2212 Sixth St.
Berkeley, CA 94710
510-644-2555 (TDD available)
510-841-8645 fax
1-800-466-4232
dredf@dredf.org
www.dredf.org
Northern California
With Parents Helping Parents, Santa Clara

Exceptional Family Support, Education and Advocacy Center
6402 Skyway
Paradise, CA 95969
530-876-8321
530-876-0346
1-888-263-1311
sea@sunset.net
www.sea-center.org

Exceptional Parents Unlimited
4440 N. First St.
Fresno, CA 93726
559-229-2000
559-229-2956 fax
epu1@cybergate.com
www.exceptionalparents.org
Central California

Loving Your Disabled Child (CPRC)
4528 Crenshaw Blvd.
Los Angeles, CA 90043
323-299-2925
323-299-4373 fax
lydc@pacbell.net
www.lydc.org
Most of LA County

Matrix
94 Galli Drive, Ste. C
Novato, CA 94949
415-884-3535
415-884-3555 fax
1-800-578-2592
alliance@matrixparents.org
www.matrixparents.org
Northern California
With Parents Helping parents, Santa Clara

Parents Helping Parents of San Francisco
594 Monterey Blvd.
San Francisco, CA 94127-2416
415-841-8820
415-841-8824 fax
sfphp@earthlink.com
Nine counties in the San Francisco Bay area

Parents Helping Parents of Santa Clara
3041 Olcott St.
Santa Clara, CA 95054-3222
408-727-5775 voice / 408-727-7655 TDD
408-727-0182 fax
info@php.com
www.php.com
Northern California
With Matrix and DREDF

Parents of Watts (CPRC)
10828 Lou Dillon Ave.
Los Angeles, CA 90059
323-566-7556
323-569-3982 fax
egertonf@hotmail.com
With Loving Your Disabled Child

Support for Families of Children with Disabilities
2601 Mission #710
San Francisco, CA 94110-3111
415-282-7494
415-282-1226 fax
sfcdmiss@aol.com
San Francisco

TASK
100 West Cerritos Ave.
Anaheim, CA 92805
714-533-8275
714-533-2533 fax
taskca@aol.com
Southern California

TASK, San Diego
3750 Convoy St., Ste. 303
San Diego, CA 92111-3741
858-874-2386
858-874-2375 fax
tasksd1@aol.com
City of San Diego and Imperial counties

Vietnamese Parents of Disabled Children Assoc., Inc. (CPRC)
7526 Syracuse Ave.
Stanton, CA 90680
310-370-6704
310-542-0522 fax
luyenchu@aol.com
With Loving Your Disabled Child

COLORADO

PEAK Parent Center, Inc.
611 North Weber, Ste. 200
Colorado Springs, CO 80903
719-531-9400 voice / 719-531-9403 TDD
719-531-9452 fax
1-800-284-0251
info@peakparent.org
www.peakparent.org

CONNECTICUT

Connecticut Parent Advocacy Center
338 Main St.
Niantic, CT. 06357
860-739-3089 voice & TDD
860-739-7460 fax (Call first to dedicate line)
1-800-445-2722 in CT
cpac@cpacinc.org
www.cpac.org

DELAWARE

Parent Information Center of Delaware (PIC/DE)
700 Barksdale Road, Ste. 16
Newark, DE 19711
302-366-0152 voice / 302-366-0178 (TDD)
302-366-0276 fax
1-888-547-4412
picofdel@picofdel.org
www.picofdel.org

DISTRICT OF COLUMBIA

Advocates for Justice and Education
2041 Martin Luther King Ave., SE, Ste. 301
Washington, DC 20020
202-678-8060
202-678-8062 fax
1-888-327-8060
justice1@bellatlantic.net
www.aje.qpg.com/

FLORIDA

Family Network on Disabilities
2735 Whitney Road
Clearwater, FL 33760-1610
727-523-1130
727-523-8687 fax
1-800-825-5736 FL only
fnd@fndfl.org
www.fndfl.org

Parent to Parent of Miami, Inc. (CPRC)
c/o Sunrise Community
9040 Sunset Drive, Ste. G
Miami, FL 33173
305-271-9797
305-271-6628 fax
PtoP1086@aol.com
Miami Dade and Monroe Counties

GEORGIA

Parents Educating Parents and Professionals for All Children (PEPPAC)
6613 East Church St., Ste. 100
Douglasville, GA 30134
770-577-7771
770-577-7774 fax
peppac@bellsouth.net
www.peppac.org

HAWAII

AWARE
200 N. Vineyard Blvd., Ste. 310
Honolulu, HI 96817
808-536-9684 voice
808-536-2280 voice & TTY
808-537-6780 fax
1-800-533-9684
ldah@gte.net

Palau Parent Network
Center on Disability Studies, University of Hawaii
1833 Kala Kaua Ave., #609
Honolulu, HI 96815
808-945-1432
808-945-1440 fax
dotty@hawaii.edu
patric@palaunet.com

IDAHO

Idaho Parents Unlimited, Inc.
4696 Overland Road, Ste. 568
Boise, ID 83705
208-342-5884 voice & TDD
208-342-1408 fax
1-800-242-4785
ipul@rmci.net
home.rmci.net/ipul

Native American Parent Training
and Information Center
129 East Third
Moscow, ID 83843
208-885-3500
208-885-3628 fax
famtog@moscow.com
Nation-wide resource for Native American families, tribes, and communities as well as parent centers and others needing information on this subject.

ILLINOIS

Designs for Change
29 East Madison, Ste. 95
Chicago, IL 60602
312-857-9292 voice / 312-857-1013 TDD
312-857-9299 fax
markse@designsforchange.org
www.dfc1.org

Family Resource Center on Disabilities
20 E. Jackson Blvd., Room 300
Chicago, IL 60604
312-939-3513 voice / 312-939-3519 TTY & TDY
312-939-7297 fax
1-800-952-4199 IL only
frcdptiil@ameritech.net
www.ameritech.net/users/frcdptiil/index

Family T.I.E.S. Network
830 South Spring
Springfield, IL 62704
217-544-5809
217-544-6018 fax
1-800-865-7842
ftiesn@aol.com
www.taalliance.org/ptis/fties

National Center for Latinos with Disabilities
1915-17 South Blue Island Ave.
Chicago, IL 60608
312-666-3393 voice / 312-666-1788 TTY
312-666-1787 fax
1-800-532-3393
ncld@ncld.com
homepage.interaccess.com/~ncld

INDIANA

IN*SOURCE
809 N. Michigan St.
South Bend, IN 46601-1036
219-234-7101
219-239-7275 TDD
219-234-7279 fax
1-800-332-4433 in IN
insourc1@aol.com
www.insource.org

IOWA

Access for Special Kids (ASK)
321 E. 6th St.
Des Moines, IA 50309
515-243-1713
515-243-1902 fax
1-800-450-8667
ptiiowa@aol.com
www.taalliance.org/ptis/ia

KANSAS

Families ACT (CPRC)
Nina Lomely-Baker
555 N. Woodlawn
Wichita, KS 67203
316-685-1821
316-685-0768 fax
nina@mhasck.org
www.mhasck.org
Sedgwick County and Outlying area

Families Together, Inc.
3340 W Douglas, Ste. 102
Wichita, KS 67203
316-945-7747
316-945-7795 fax
1-888-815-6364
fmin@feist.com
www.kansas.net/~family

KENTUCKY

FIND of Louisville
1146 South Third St.
Louisville, KY 40203
502-584-1239
502-584-1261 fax
1-800-525-7746
info@council-crc.org
www.council-crc.org

LOUISIANA

Pyramid Parent Training Program (CPRC)
4101 Fontainbleau Dr.
New Orleans, LA 70125
504-827-0610
504-827-2999 fax
dmarkey404@aol.com

Project PROMPT
4323 Division Street, Ste. 110
Metairie, LA 70002-3179
504-888-9111
504-888-0246 fax
1-800-766-7736
fhfgno@ix.netcom.com
www.projectprompt.com

MAINE

Special Needs Parent Info Network
P.O. Box 2067
Augusta, ME 04338-2067
207-582-2504
207-582-3638 fax
1-800-870-7746
jlachance@mpf.org
www.mpf.org

MARYLAND

Parents Place of Maryland, Inc.
7484 Candlewood Rd. Ste. S
Hanover, MD 21076-1306
410-859-5300 voice & TDD
410-859-5301 fax
info@ppmd.org
www.ppmd.org

MASSACHUSETTS

Federation for Children with Special Needs
1135 Tremont St., Ste. 420
Boston, MA 02120-2140
617-236-7210 (voice and TTY)
617-572-2094 fax
1-800-331-0688 in MA
fcsninfo@fcsn.org
www.fcsn.org/

Urban / PRIDE
1472 Tremont
Roxbury Crossing, MA 02120
617-445-3191
617-445-6309 fax
1-800-331-0688 in MA
cspinkstion@compassinc.com

IPEST
P.O. Box 4081
Vineyard Haven, MA 02568
508-693-8612
508-693-7111 fax
ckennedy@fastdial.net

MICHIGAN

CAUSE
3303 W. Saginaw, Ste. F-1
Lansing, MI 48917-2303
517-886-9167 voice & TDD & TDY
517-886-9775 fax
1-800-221-9105 in MI
info-cause@voyager.net
www.pathwaynet.com/cause

"Parents are Experts" Parents Training Parents
23077 Greenfield Road, Ste. 205
Southfield, MI 48075-3745
248-557-5070 voice & TDD
248-557-4456 fax
1-800-827-4843
ucp@ameritech.net
www.taalliance.org/ptis/mi-parents
Wayne County

MINNESOTA

PACER Center, Inc.
8161 Normandale Blvd.
Minneapolis, MN 55437-1044
952-838-9000 voice
952-838-0190 TTY
952-838-0199 fax
1-800-537-2237 in MN
pacer@pacer.org
www.pacer.org

MISSISSIPPI

Parent Partners
7 Lakeland Circle
Jackson, MS 39216
601-982-1988
601-982-5792 fax
1-800-366-5707 in MS
ptiofms@misnet.com
www.taalliance.org/ptis/ms

Project Empower (CPRC)
136 South Poplar Ave.
Greenville, MS 38701
601-332-4852
601-332-1622 fax
1-800-337-4852
empower@tecinfo.com

MISSOURI

Missouri Parents Act (MPACT)
1 West Armour, Ste. 302
Kansas City, MO 64111
816-531-7070
816-931-2992 TDD
816-531-4777 fax
ptijcj@aol.com
www.crn.org/mpact

MONTANA

Parents Let's Unite for Kids
516 N. 32nd St.
Billings, MT 59101
406-255-0540
406-255-0523 fax
1-800-222-7585 in MT
plukinfo@pluk.org
www.pluk.org

NEBRASKA

Nebraska Parents Center
1941 South 42nd St., #122
Omaha, NE 68105-2942
402-346-0525 voice & TDD
402-346-5253 fax
1-800-284-8520
gdavis@neparentcenter.org
www.neparentcenter.org

NEVADA

Nevada Parents Encouraging Parents (PEP)
2810 W. Charleston Blvd., Ste. G-68
Quail Park IV
Las Vegas, NV 89102
702-388-8899
702-388-2966 fax
1-800-216-5188
nvpep@vegas.infi.net
www.nvpep.org

NEW HAMPSHIRE

Parent Information Center
P.O. Box 2405
Concord, NH 03302-2405
603-224-7005 (voice & TDD)
603-224-4379 fax
1-800-232-0986 in NH
picnh@aol.com
www.taalliance.org/ptis/nhpic

NEW JERSEY

Statewide Parent Advocacy Network (SPAN)
35 Halsey Street, 4th Floor
Newark, NJ 07102
973-642-8100
973-642-8080 fax
1-800-654-SPAN
span@spannj.org
www.spannj.org

NEW MEXICO

Parents Reaching Out, Project ADOBE
1000-A Main St. NW
Los Lunas, NM 87031
505-865-3700 voice & TDD
505-865-3737 fax
1-800-524-5176 in NM
nmproth@aol.com
www.parentsreachingout.org

EPIC Project
412 Camino Don Thomas, P.O. Box 788
Bernalillo, NM 87004-0788
505-867-3396
505-867-3398 fax
1-800-524-5176 in NM
epics@swcr.org

NEW YORK

The Advocacy Center
277 Alexander St., Ste. 500
Rochester, NY 14607
716-546-1700
716-546-7069 fax
1-800-650-4967 (NY only)
advocacy@frontiernet.net
www.advocacycenter.com
Statewide except for NY city.

Advocates for Children of NY
151 West 50th St., 5th Floor
New York, NY 10001
212-947-9779
212-947-9790 fax
aespada@advocatesforchildren.org
www.advocatesforchildren.org
Five boroughs of New York City

Resources for Children with Special Needs, Inc.
200 Park Ave. South, Ste. 816
New York, NY 10003
212-677-4650
212-254-4070 fax
info@resourcesnyc.org
www.resourcesnyc.org
New York City (Bronx, Brooklyn, Manhattan, Queens, Staten Island)

Sinergia/Metropolitan Parent Center
15 West 65th St., 6th Floor
New York, NY 10023
212-496-1300
212-496-5608 fax
dalsinergia@worldnet.att.net
www.panix.com/~sinergia
New York City

United We Stand (CPRC)
312 South 3rd St.
Brooklyn, NY 11211
718-302-4313
718-302-4315 fax
uwsofny@aol.com
www.taalliance.org/ptis/uws

NORTH CAROLINA

ECAC, Inc.
P.O. Box 16
Davidson, NC 28036
704-892-1321
704-892-5028 fax
1-800-962-6817 NC only
ECAC1@aol.com
www.ecac-parentcenter.org

NORTH DAKOTA

ND Pathfinder Parent Training
And Information Center
Arrowhead Shopping Center
1600 2nd Ave. SW, Ste. 19
Minot, ND 58701-3459
701-837-7500 voice / 701-837-7501 TDD
701-837-7548 fax
1-800-245-5840 ND only
ndpath01@minot.ndak.net
www.pathfinder.minot.com

OHIO

Child Advocacy Center
Cathy Heizman
1821 Summit Road, Ste. 303
Cincinnati, OH 45237
513-821-2400
513-821-2442 fax
CADCenter@aol.com
Southwestern Ohio, Northern Kentucky, Dearborn County, Indiana

OCECD
Bank One Building
165 West Center St., Ste. 302
Marion, OH 43302-3741
740-382-5452 voice & TDD
740-383-6421 fax
1-800-374-2806
ocecd@gte.net
www.taalliance.org/PTIs/regohio/

OKLAHOMA

Oklahoma Parents Center, Inc.
4600 Southeast 29th St.
Del City, OK 73115-4224
405-619-0500
405-670-0776 fax
1-800-759-4142
okparentctr@aol.com
www.taalliance.org/ptis/ok

OREGON

Oregon COPE Project
999 Locust St. NE
Salem, OR 97303
503-581-8156 voice & TDD
503-391-0429 fax
1-888-505-COPE
orcope@open.org
www.open.org/~orcope

PENNSYLVANIA (CPRC)

Hispanos Unidas para Niños Excepcionales
(Hispanics United for Exceptional Children)
Buena Vista Plaza
166 W. Lehigh Ave., Ste. 101
Philadelphia, PA 19133-3838
215-425-6203
215-425-6204 fax
huneinc@aol.com
City of Philadelphia, occasional service to surrounding counties

Parent Education Network
2107 Industrial Hwy.
York, PA 17402-2223
717-600-0100 voice & TTY
717-600-8101 fax
1-800-522-5827 in PA
1-800-441-5028 (Spanish in PA)
pen@parentednet.org
www.parentednet.org

The Mentor Parent Program
P.O. Box 47
Philadelphia, PA 16340
814-563-3470
814-563-3445 fax
gal97@penn.com

PUERTO RICO

APNI
P.O. Box 21280
Ponce de Leon 724
San Juan, PR 00928-1280
787-763-4665
787-765-0345 fax
1-800-981-8492
apnipr@prtc.net
Island of Puerto Rico

RHODE ISLAND

RI Parent Information Network
175 Main St.
Pawtucket, RI 02860
401-727-4144 voice / 401-727-4151 TDD
401-727-4040 fax
1-800-464-3399 in RI
collins@ripin.org
http://www.ripin.org

SOUTH CAROLINA

Parent Training & Resource Center (CPRC)
c/o Family Resource Center
135 Rutledge Ave., P.O. Box 250567
Charleston, SC 29425
843-876-1519
843-876-1518 fax
mccarthyb@musc.edu
Tri-county: Charleston, Berkeley, and Dorchester

PRO-PARENTS
2712 Middleburg Drive, Ste. 203
Columbia, SC 29204
803-779-3859 voice
803-252-4513 fax
1-800-759-4776 in SC
proparents@aol.com
www.proparents.org

SOUTH DAKOTA

South Dakota Parent Connection
3701 West 49th St., Ste. 200B
Sioux Falls, SD 57106
605-361-3171 voice & TDD
605-361-2928 fax
1-800-640-4553 in SD
bpete@dakota.net
www.sdparent.org

TENNESSEE

Support and Training for Exceptional Parents, Inc. (STEP)
424 E. Bernard Ave., Ste. 3
Greeneville, TN 37745
423-639-0125 voice / 636-8217 TDD
423-636-8217 fax
1-800-280-STEP in TN
tnstep@aol.com
www.tnstep.org

TEXAS

El Valle Community Parent Resource Center (CPRC)
530 South Texas Blvd., Ste. J
Weslaco, TX 78596
956-969-3611
956-969-8761 fax
1-800-680-0255 TX only
texasfiestaedu@acnet.net
www.tfepoder.org
Cameron, Willacy, & Starr Counties.

The Arc of Texas in the Rio Grande Valley
Parents Supporting Parents Network (CPRC)
601 N Texas Blvd.
Weslaco, TX 78596
956-447-8408
956-973-9503 fax
1-888-857-8688
ljzuniga@earthlink.net
www.thearcoftexas.org

Partners Resource Network Inc.
1090 Longfellow Drive, Ste. B
Beaumont, TX 77706-4819
409-898-4684 voice & TDD
409-898-4869 fax
1-800-866-4726 in TX
txprn@pnx.com
www.PartnersTX.org

Project PODER
1017 N. Main Ave., Ste. 207
San Antonio, TX 78212
210-222-2637
210-475-9283 fax
1-800-682-9747 TX only
poder@tfepoder.org
www.tfepoder.org
San Antonio, Hondo, & Castroville. Cameron, Hidalgo, Willacy, & Starr Counties.

UTAH

Utah Parent Center
2290 East 4500 S., Ste. 110
Salt Lake City, UT 84117-4428
801-272-1051
801-272-8907 fax
1-800-468-1160 in UT
upc@inconnect.com
www.utahparentcenter.org

VERMONT

Vermont Parent Information Center
1 Mill Street, Ste. A7
Burlington, VT 05401
802-658-5315 voice & TDD
802-658-5395 fax
1-800-639-7170 in VT
vpic@together.net
www.vtpic.com

VIRGIN ISLANDS

V.I. FIND
#2 Nye Gade
St. Thomas, US VI 00802
340-774-1662
340-774-1662 fax
vifind@islands.vi
www.taalliance.org/ptis/vifind

VIRGINIA (CPRC)

PADDA, Inc.
Mark Jacob
813 Forrest Drive, Ste. 3
Newport News, VA 23606
757-591-9119
757-591-8990 fax
1-888-337-2332
webmaster@padda.org
www.padda.org

Parent Educational Advocacy Training Center
6320 Augusta Drive
Springfield, VA 22150
703-923-0010
703-923-0030 fax
1-800-869-6782 VA only
partners@peatc.org
www.peatc.org

WASHINGTON

Parent to Parent Power (CPRC)
1118 S 142nd St.
Tacoma, WA 98444
253-531-2022
253-538-1126 fax
yvonne_link@yahoo.com

PAVE/STOMP
6316 South 12th St., Ste. B
Tacoma, WA 98465
253-565-2266 voice & TTY
253-566-8052 fax
1-800-572-7368
hhebdon@washingtonpave.com
www.washingtonpave.org.
U.S. military installations; and parent centers and others needing information on this subject.

Washington PAVE
6316 South 12th St., Ste. B
Tacoma, WA 98465-1900
253-565-2266 (voice & TDD)
253-566-8052 fax
1-800-572-7368 in WA
jbutts@washingtonpave.com
www.washingtonpave.org

WEST VIRGINIA

West Virginia PTI
Pat Haberbosch
371 Broaddus Ave.
Clarksburg, WV 26301
304-624-1436 voice & TTY
304-624-1438
1-800-281-1436 in WV
wvpti@aol.com
www.wvpti.org

WISCONSIN

Native American Family Empowerment Center
Great Lakes Inter-Tribal Council, Inc.
2932 Hwy. 47N, P.O. Box 9
Lac du Flambeau, WI 54538
715-588-3324
715-588-7900
1-800-472-7207 (WI only)
drosin@newnorth.net

Parent Education Project of Wisconsin
2192 South 60th St.
West Allis, WI 53219-1568
414-328-5520 voice / 414-328-5525 TDD
414-328-5530
1-800-231-8382 (WI only)
PMColletti@aol.com
members.aol.com/pepofwi

Wisconsin Family Assistance Center for Education, Training and Support (CPRC)
2714 North Dr. Martin Luther King Dr., Ste. E
Milwaukee, WI 53212
414-374-4645 / 414-374-4635 TTD
414-374-4655 fax
wifacets@execpc.com

WYOMING

Parent Information Center
5 North Lobban
Buffalo, WY 82834
307-684-2277 voice & TDD
307-684-5314
1-800-660-9742 WY only
tdawsonpic@vcn.com
www.wpic.org

State Medicaid Offices

ALABAMA

Medicaid Agency
501 Dexter Ave.
P.O. Box 5624
Montgomery, AL 36103-5624
(334) 242-5010
www.medicaid.state.al.us

ALASKA

Division of Medical Assistance
HSS Department
P.O. Box 110660
Juneau, AK 99811-0660
(907) 465-3355
www.hss.state.ak.us/dma/table.htm

ARIZONA

Health Care
Cost Containment
801 East Jefferson
Phoenix, AZ 85034
(602) 417-4000
www.ahcccs.state.az.us

ARKANSAS

Office of Long Term Care
DHS, P.O. Box 1437, Slot 400
Little Rock, AR 72203-1437
(501) 682-8292
www.medicaid.state.ar.us

CALIFORNIA

Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814
(916) 445-4171
www.dhs.cahwnet.gov/mcs/index.htm

Bureau of Health
Department of Health Care Policy and Financing
1575 Sherman St.
Denver, CO 80203-1714
(303) 866-2993
www.chcpf.state.co.us

CONNECTICUT

Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
(800) 842-1508
www.dss.state.ct.us

DELAWARE

Department of HSS
Delaware State Hospital
1901 North Dupont Hwy.
New Castle, DE 19720
(302) 577-4901
www.state.de.us/dhss/dss/dsshome.htm

DISTRICT OF COLUMBIA

Office of Health Care Financing, DC DHS
2100 Martin Luther King Ave. SE, Ste. 302
Washington, DC 20020
(202) 727-0735
www.dchealth.com/maa

FLORIDA

Agency for Health Care Administration
2727 Mahan Drive
Tallahassee, FL 32308
(850) 922-3809
www.fdhc.state.fl.us

GEORGIA

Division of Medical Assistance
2 Peachtree St. NW
Suite 4043
Atlanta, GA 30303-3159
(404) 656-4479
www.communityhealth.state.ga.us

HAWAII

Health Care Administration Division
P.O. Box 339
Honolulu, HI 96809-0339
(808) 586-5391
www.state.hi.us/dhs

IDAHO

Department of Health and Welfare
Towers Building, 2nd Floor
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5500
www2.state.id.us/dhw/benefits/Benefits.htm

ILLINOIS

Department of Public Aid
201 S. Grand Ave. E., 3rd Fl.
Springfield, IL 62763-0001
(217) 782-1200
www.state.il.us/dpa

INDIANA

Medicaid Policy & Planning
Family and Social Services Administration
402 Washington St., Rm. 382
Indianapolis. IN 46207
(317) 233-7382
www.ai.org/fssa/index.html

IOWA

Division of Medical Services
DHS, Hoover S.O.B.
Des Moines, IA 50319
(800) 972-2017
www.dhs.state.ia.us/HomePages/DHS/medical.htm

KANSAS

Social and Rehabilitation Services
Docking Office Bldg., Rm. 628-S
915 Harrison Street
Topeka, KS 66612
(800) 766-9012
www.ink.org/public/srs

KENTUCKY

Medicaid Services
275 East Main St.
Third Floor
Frankfort, KY 40621
(502) 564-6885
chs.state.ky.us/dms

LOUISIANA

Bureau of Health Services
P.O. Box 91030
Baton Rouge, LA 70821
(225) 342-5774
www.dhh.state.la.us/MEDICAID

MAINE

Bureau of Medical Services, DHS
State House Station 11
Augusta, ME 04333
(207) 624-7539
www.state.me.us/bms

MARYLAND

Department of Health and Mental Hygiene
201 W. Preston Street
Baltimore, MD 21201
(410) 767-10432
www.dhmh.state.md.us/healthchoice

MASSACHUSETTS

Division of Medical Assistance
600 Washington St.
Boston, MA 02111
(800) 841-2900
www.state.ma.us/dma

MICHIGAN

Medical Services Administration DSS
Lewis Cass Building
320 South Walnut
Lansing, MI 48913
(517) 335-5121
www.mdch.state.mi.us/msa/mdch_msa/msahome.HTM

MINNESOTA

Health Care Administration
Department of Human Services
444 Lafayette Road, 2nd fl.
St. Paul, MN 55155-3815
(612) 297-3933
www.dhs.state.mn.us

MISSISSIPPI

Division of Medicaid
Robert E. Lee Bldg., Rm. 801
239 Lamar Street
Jackson, MS 39201-1399
(601) 359-6056
www.dom.state.ms.us

MISSOURI

Division of Medical Services
DSS, 615 Hoveton Ct.
Box 6500
Jefferson City, MO 65102
(573) 751-3425
www.dss.state.mo.us/dms

MONTANA

Medicaid Services Division
1400 Broadway
P.O. Box 20295
Helena, MT 59604-4210
(406) 444-4540
www.dphhs.state.mt.us/hpsd/medicaid

NEBRASKA

Medical Services Division
301 Centennial Mall S. 5th floor
Lincoln, NE 68509-5026
(402) 471-9147
www.hhs.state.ne.us

NEVADA

Division of Health Care Finance and Policy
1100 E. William St., Rm. 119
Carson City, NV 89701
(775) 687-4176
www.state.nv.us/dhcfp

NEW HAMPSHIRE

Office of Medical Services DHS
29 Pleasant St.
Concord, NH 03301-6505
(800) 852-3345
www.dhhs.state.nh.us

NEW JERSEY

Med. Assistance and Health Services
DHS, CN-712-7
Quakerbridge Plaza
Trenton, NJ 08625
(609) 588-2600
www.state.nj.us/humanservices

NEW MEXICO

Medical Assistance Division
Human Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
(800) 432-6217
www.state.nm.us/hsd/home.html

NEW YORK

Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237
(518) 486-4803
www.health.state.ny.us

NORTH CAROLINA

Division of Medical Assistance
DHR, P.O. Box 29529
1985 Umstead Drive
Raleigh, NC 27626-0529
(919) 857-4019
www.dhhs.state.nc.us/dma

NORTH DAKOTA

Medical Operations
DHS, State Capitol Bldg., Judicial wing
600 E. Boulevard Ave.
Bismarck, ND 58505-0261
(701) 328-2321
www.state.nd.us/humanservices

OHIO

Ohio Department of Job and Family Services
30 East Broad St.
Columbus, OH 43266-0423
(614) 644-0140
www.state.oh.us/odjfs/ohp

OKLAHOMA

Health Care Authority
4545 North Lincoln Blvd., Ste. 124
Oklahoma City, OK 73105
(405) 530-3439
www.ohca.state.ok.us

OREGON

Office of Medical Assistance Programs
Human Resources Bldg. 3rd floor
500 Summer St. NE
Salem, OR 97310-1014
(503) 945-5811
www.sdsd.hr.state.or.us

PENNSYLVANIA

Department of Public Welfare
Room 333, Box 2675
Harrisburg, PA 17105-2675
(800) 692-7462
www.dpw.state.pa.us

RHODE ISLAND

Division of Medical Services DHS
600 New London Ave.
Cranston, RI 02920
(401) 222-7000
www.dhs.state.ri.us

SOUTH CAROLINA

Health and Human Services
Finance Commission
Box 8206
Columbia, SC 29202-8206
(803)) 898-2500
www.state.sc.us/dhhs

SOUTH DAKOTA

Medical Services
DSS, 700 Governors Drive
Kniep Building
Pierre, SD 57501-2291
(605) 773-3165
www.state.sd.us/social/social

TENNESSEE

Bureau of Medicaid
729 Church Street
Nashville, TN 37247-6501
(800) 669-1815
www.state.tn.us/humanserv

TEXAS

Department of Human Services
701 W. 51st Street
Austin, TX 78751
(512) 438-3280
www.dhs.state.tx.us

UTAH

Division of Health Care Financing
288 North, 1460 West, 3rd fl.
Salt Lake City, UT 84116-0580
(800) 662-9651
hlunix.ex.state.ut.us/medicaid

VERMONT

Division of Medicaid
DSW Vermont Human Services
103 South Main Street
Waterbury, VT 05671-1201
(802) 241-2880
www.ahs.state.vt.us

VIRGINIA

Medical Assistance Services
600 East Broad St., Ste. 1300
Richmond, VA 23219
(804) 786-7933
www.cns.state.va.us/dmas

WASHINGTON

Medical Assistance Administration
Department of Health and Human Services
P.O. Box 45080
Olympia, WA 98504-5080
(800) 562-3022
maa.dshs.wa.gov

WEST VIRGINIA

Bureau of Medical Services
Health and Human Resources
Room 251, 350 Capitol Street
Charleston, WV 25301-3706
(303) 558-1700
www.wvdhhr.org/bms

WISCONSIN

Bureau of Health Care Financing
DHSS, P.O. Box 309
West Wilson St., Room 250
Madison, WI 53701-0309
(608) 266-2522
www.dhfs.state.wi.us/Medicaid

WYOMING

Division of Health Care Financing
6101 Yellowstone Road
Cheyenne, WY 82002
(307) 777-7531
wdhfs.state.wy.us/WDH/default.htm

Values and Principles for the CASSP System of Care

Core Values for the System of Care

1. The system of care should be child-centered and family-focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community-based, with the focus of services as well as management and decision-making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles for the System of Care

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potential of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.

4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that the children can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbances should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbances should receive services without regard to race, religion, national origin, sex, physical disability or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

COMPONENTS OF THE SYSTEM OF CARE

1. MENTAL HEALTH SERVICES

   Nonresidential services

   Prevention

   Early Identification and Intervention

   Assessment

Outpatient treatment
Home-based services
Day treatment
Emergency services

Residential Services
Therapeutic foster care
Therapeutic group care
Therapeutic camp services
Independent living services
Crisis residential services

Inpatient hospitalization

2. SOCIAL SERVICES
   Protective services
   Financial services
   Home Aid services
   Respite care
   Shelter services
   Foster care
   Adoption

3. EDUCATIONAL SERVICES
   Assessment and planning
   Resource rooms
   Self-contained classrooms
   Special schools
   Homebound instruction
   Alternative programs

4. HEALTH SERVICES
   Health education and prevention
   Screening and assessment
   Primary care
   Acute care
   Long-term care

5. VOCATIONAL SERVICES
   Career education
   Vocational assessment
   Job survival skills training
   Vocational skills training
   Work experiences
   Job finding, placement, and retention services
   Supported employment

6. RECREATIONAL SERVICES
   Relationship with significant other
   After school programs
   Summer camps
   Special Recreational Projects

7. OPERATIONAL SERVICES
   Case management
   Self-help, support groups
   Advocacy
   Transportation
   Legal services
   Volunteer programs

PACER CENTER

www.pacer.org